

53 7001

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7001  
Registered No.

BIRTH NO. .

1. NAME OF DECEASED (Type or Print) <b>MRS. CHARLOTTE C. ENGLE</b>			2. DATE OF DEATH <b>August 2, 1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) STATE <b>Pennsylvania</b> B. COUNTY <b>V-35</b>		
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>York</b>		
6. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>613 Vander Ave.</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 12, 1911</b>		9. AGE (In years last birthday) <b>42</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Presser</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Nightwear Co.</b>	11. BIRTHPLACE (State or foreign country) <b>York, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Robert C. Guise</b>			14. MOTHER'S MAIDEN NAME <b>Daisy Ellen Smith</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Husband</b>		
			ADDRESS <b>Same</b>		

18-163X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Carcinoma of lung.**  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)   
DUE TO  
(C)   

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

**Pneumonia**

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 26, 1953</b> to <b>August 2, 1953</b> that I last saw the deceased alive on <b>August 2, 1953</b> and that death occurred at <b>2:05 P.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>J. Brown</b>		23B. ADDRESS <b>Union Memorial Hsp.</b>		23C. DATE SIGNED <b>Aug 2, 1953</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>8/2/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt Hope Cem.</b>	
				24D. LOCATION (City, town, or county) (State) <b>York Pa.</b>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>		25. FUNERAL DIRECTOR <b>W. B. Galt, Inc.</b>	
				ADDRESS <b>Baltimore</b>	

69046

STATE OF NEW YORK  
CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Birth		6. Usual Residence		7. Cause of Death		8. Manner of Death	
9. Name of Physician		10. Name of Undertaker		11. Name of Burial Place		12. Name of Funeral Home	
13. Name of Coroner		14. Name of Medical Examiner		15. Name of Pathologist		16. Name of Anatomist	
17. Name of Registrar		18. Name of Clerk		19. Name of Nurse		20. Name of Embalmer	
21. Name of Burial Place		22. Name of Funeral Home		23. Name of Coroner		24. Name of Medical Examiner	
25. Name of Pathologist		26. Name of Anatomist		27. Name of Registrar		28. Name of Clerk	
29. Name of Nurse		30. Name of Embalmer		31. Name of Burial Place		32. Name of Funeral Home	
33. Name of Coroner		34. Name of Medical Examiner		35. Name of Pathologist		36. Name of Anatomist	
37. Name of Registrar		38. Name of Clerk		39. Name of Nurse		40. Name of Embalmer	
41. Name of Burial Place		42. Name of Funeral Home		43. Name of Coroner		44. Name of Medical Examiner	
45. Name of Pathologist		46. Name of Anatomist		47. Name of Registrar		48. Name of Clerk	
49. Name of Nurse		50. Name of Embalmer		51. Name of Burial Place		52. Name of Funeral Home	
53. Name of Coroner		54. Name of Medical Examiner		55. Name of Pathologist		56. Name of Anatomist	
57. Name of Registrar		58. Name of Clerk		59. Name of Nurse		60. Name of Embalmer	
61. Name of Burial Place		62. Name of Funeral Home		63. Name of Coroner		64. Name of Medical Examiner	
65. Name of Pathologist		66. Name of Anatomist		67. Name of Registrar		68. Name of Clerk	
69. Name of Nurse		70. Name of Embalmer		71. Name of Burial Place		72. Name of Funeral Home	
73. Name of Coroner		74. Name of Medical Examiner		75. Name of Pathologist		76. Name of Anatomist	
77. Name of Registrar		78. Name of Clerk		79. Name of Nurse		80. Name of Embalmer	
81. Name of Burial Place		82. Name of Funeral Home		83. Name of Coroner		84. Name of Medical Examiner	
85. Name of Pathologist		86. Name of Anatomist		87. Name of Registrar		88. Name of Clerk	
89. Name of Nurse		90. Name of Embalmer		91. Name of Burial Place		92. Name of Funeral Home	
93. Name of Coroner		94. Name of Medical Examiner		95. Name of Pathologist		96. Name of Anatomist	
97. Name of Registrar		98. Name of Clerk		99. Name of Nurse		100. Name of Embalmer	



H-520  
53 7002BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

53 7002

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <u>ROSA B HINES</u>		2. DATE OF DEATH <u>Aug. 2 '53</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Balt. Md.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <u>Lutheran Hospital of Maryland</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>	
D. STREET ADDRESS (If rural, give location) <u>2110 Mt. Holly St. #16</u>		E. LENGTH OF STAY IN BALTIMORE Yrs. _____ Mos. _____ Days _____	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Wid.</u>	8. DATE OF BIRTH <u>5/12/1884</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW.</u>		10B. KIND OF BUSINESS OR INDUSTRY _____	9. AGE (In years last birthday) <u>69</u>
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME _____		14. MOTHER'S MAIDEN NAME _____	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Daughter - GRACE Hamilton</u>		ADDRESS <u>Same</u>	

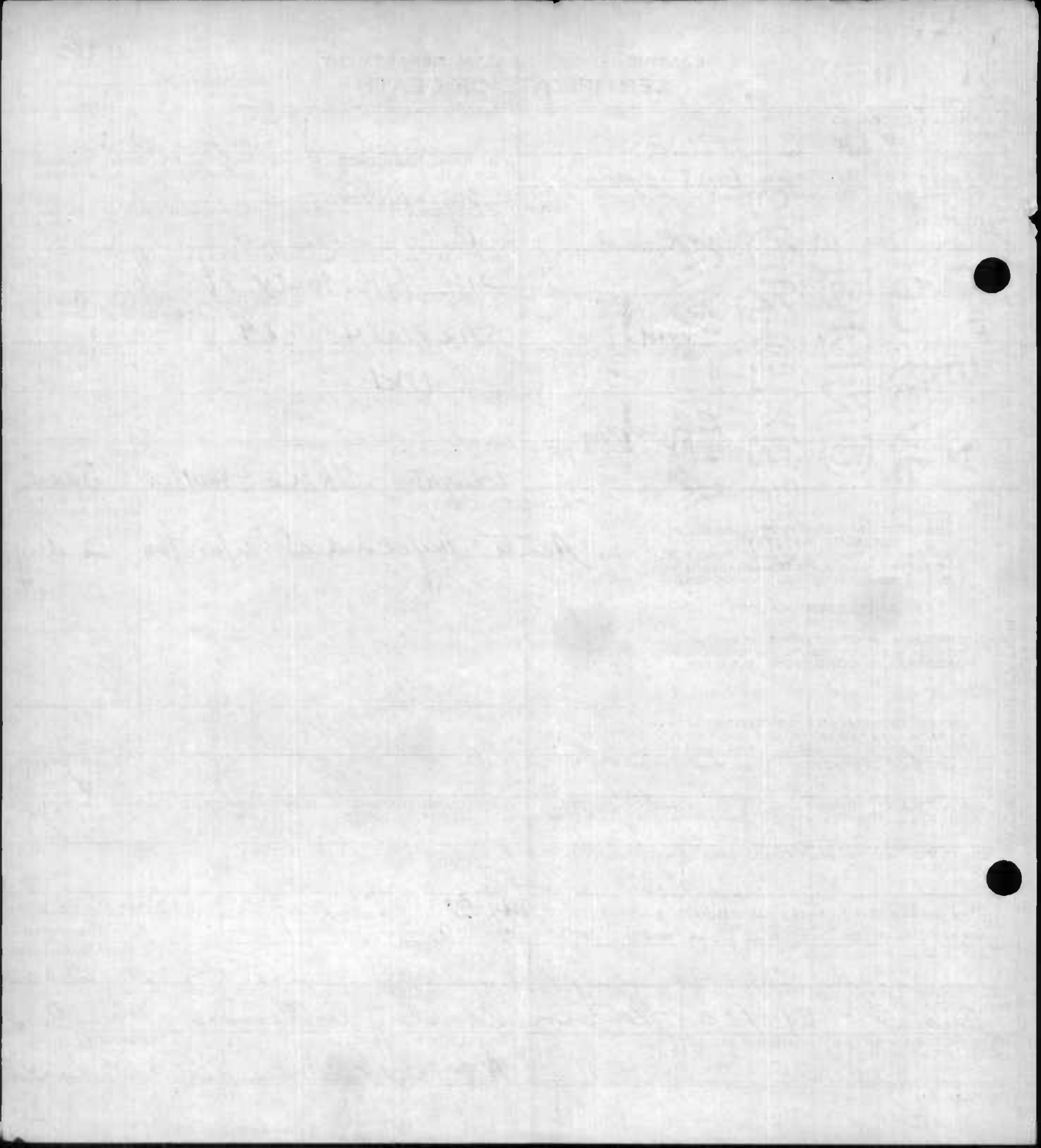
18. <u>420.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarction</u>	CAUSE OF DEATH (A) _____ DUE TO (B) _____ DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <u>2</u>		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	

22. I hereby certify that I attended the deceased from Aug. 2, 1953, to Aug. 2, 1953, that I last saw the deceased alive on Aug. 2, 1953, and that death occurred at 2:50 m., from the causes and on the date stated above.

23A. SIGNATURE <u>ROSA Hines</u>		23B. ADDRESS <u>Lutheran Hospital</u>		23C. DATE SIGNED <u>Aug. 2 '53</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/5/53</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		24E. LOCATION (State) _____		24F. LOCATION (Country) _____	

DATE RECEIVED BY LOCAL REGISTRAR <u>AUG 3 1953</u>		REGISTRAR'S SIGNATURE <u>Huntington Williams, M.D.</u>		25. FUNERAL DIRECTOR <u>Wm. C. B. Inc.</u>	
ADDRESS _____		ADDRESS _____		ADDRESS _____	



53 7003

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7003

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Ada B. Upton

2. DATE  
OF  
DEATH

July 31, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Anne Arundel

B. FULL NAME OF HOSPITAL OR INSTITUTION

S. Baltimore General Hosp.

C. CITY OR TOWN

Severn

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Route #2

C. Length of stay in Baltimore

D. O. A.

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 13, 1879

9. AGE (In years last birthday)

74

If Under 1 Year Months: Days  
If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

R.R. Conductor (retired)

10B. KIND OF BUSINESS OR INDUSTRY

Pennsylvania R.R.

11. BIRTHPLACE (State or foreign country)

Anne Arundel Co., Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Thomas W. Upton

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Mrs. Carrie V. Upton

ADDRESS

Severn, Md.

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Coronary Thrombosis

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

2 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ AT WORK  
AT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1952 to 7-31, 1953 that I last saw the deceased alive on 7-31, 1953, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

C. B. McDonald

M. D.

23B. ADDRESS

Esley Burnie Md

23C. DATE SIGNED

7-31-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

August 3, 1953

24C. NAME OF CEMETERY OR CREMATORY

Landon Park Cem.

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

AUG 3 1953

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Richard V. Singleton, Esley Burnie, Md.

ADDRESS

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

STATE OF NEW YORK

DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

OFFICE OF THE REGISTRAR

ALBANY, N. Y.

STATE OF NEW YORK

DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

OFFICE OF THE REGISTRAR

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STATE OF NEW YORK

DEPARTMENT OF HEALTH

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STATE OF NEW YORK

DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

OFFICE OF THE REGISTRAR

ALBANY, N. Y.

STATE OF NEW YORK

DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

OFFICE OF THE REGISTRAR

ALBANY, N. Y.

C-320

53 7004

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7004  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Cates Lilly

2. DATE  
OF  
DEATH

7-30-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Franklin Syvan Hospital

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

8748 Jasper St. JASPER ST

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

4.1.20

9. AGE (In years  
last birthday)

33

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laundress

10B. KIND OF BUSINESS OR  
INDUSTRY

1

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

2

14. MOTHER'S MAIDEN NAME

2

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

M. Cates 6488 Jasper

CAUSE OF DEATH

18. 587.0

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

acute pancreatitis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

7/29-53

19B. MAJOR FINDINGS OF OPERATION

Indurated Pancreas. Acute pancreatitis.

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from 7/29, 1953 to 7/30, 1953 that I last saw the  
deceased alive on 7/31, 1953, and that death occurred at 5:15 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Stehmel

M. D.

23B. ADDRESS

Franklin Syvan Hospital

23C. DATE SIGNED

7/31/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

Aug 3

24C. NAME OF CEMETERY OR CREMATORY

W. C. Allen

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

ADDRESS

W. C. Allen 918 S. Kent Ave

CERTIFICATE OF DEATH

STATE OF TEXAS

COUNTY OF DALLAS

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

RELIGION

MARRIAGE

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH



5-432  
53 7005  
BIRTH NO. 53-17734

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7005  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>Schultheiss, Baby Boy</b>		2. DATE OF DEATH <b>Aug. 2, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR <del>LOCATION</del> <b>St. Joseph's</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
D. STREET ADDRESS (If rural, give location) <b>3152 Ravenwood Avenue</b>		E. LENGTH OF stay in Baltimore <b>1 da.</b> Yrs. Mos. Days	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Aug. 2, 1953</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13. FATHER'S NAME <b>Herman Norman Conrad Schultheiss</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Katherine Koerber</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	

18. <b>761.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Premature separation of placenta</b> DUE TO <b>CAUSE OF DEATH</b> <b>INTERVAL BETWEEN ONSET AND DEATH</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(B)</b> DUE TO <b>(C)</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>August 2, 1953</b> , to <b>August 2, 1953</b> that I last saw the deceased alive on <b>August 2, 1953</b> , and that death occurred at <b>2:25pm.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Desmond E. Tawstas</b>		23B. ADDRESS <b>1100 N. Caroline Street</b>		23C. DATE SIGNED <b>Aug. 2, 1953</b>	
24A. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-3-53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION (City, town, or county) <b>Balto Md</b>		24E. NAME OF FUNERAL DIRECTOR <b>Huntington H. ...</b>		24F. ADDRESS <b>17 D. D. Rock - 5305 Harford Rd</b>	

STATEMENT OF DEATH  
CERTIFICATE OF DEATH

Blank form with horizontal lines for text entry.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

53 7006

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)M.  
RUSSELL TIMMONS2. DATE  
OF  
DEATH

8-1-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Univ. Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE 9-06

D. STREET ADDRESS (If rural, give location)

2037 E. 31st St.

E. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

1-8-12

9. AGE (In years last birthday)

41

H Under 1 Year

Months: Days

H Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Bus + Elct Co

10B. KIND OF BUSINESS OR INDUSTRY

DRAFTSMAN

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

WALLACE M TIMMONS

14. MOTHER'S MAIDEN NAME

LOUISE ZIMMERMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

212-14-5661

17. INFORMANT

WIFE Timmons 2037 E 31st St

ADDRESS

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Intercerebral Vascular Accident 3 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Hypertension

unknown

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-1, 1953, to 8-1, 1953, that I last saw the deceased alive on 8-1, 1953, and that death occurred at 5:10 Pm., from the causes and on the date stated above.

23A. SIGNATURE

Frank J. Kuehn M.D.

23B. ADDRESS

Univ. Hospital

23C. DATE SIGNED

8/2/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-5-53

24C. NAME OF CEMETERY OR CREMATORY

Moreland Park

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 3 1953

REGISTRAR'S SIGNATURE

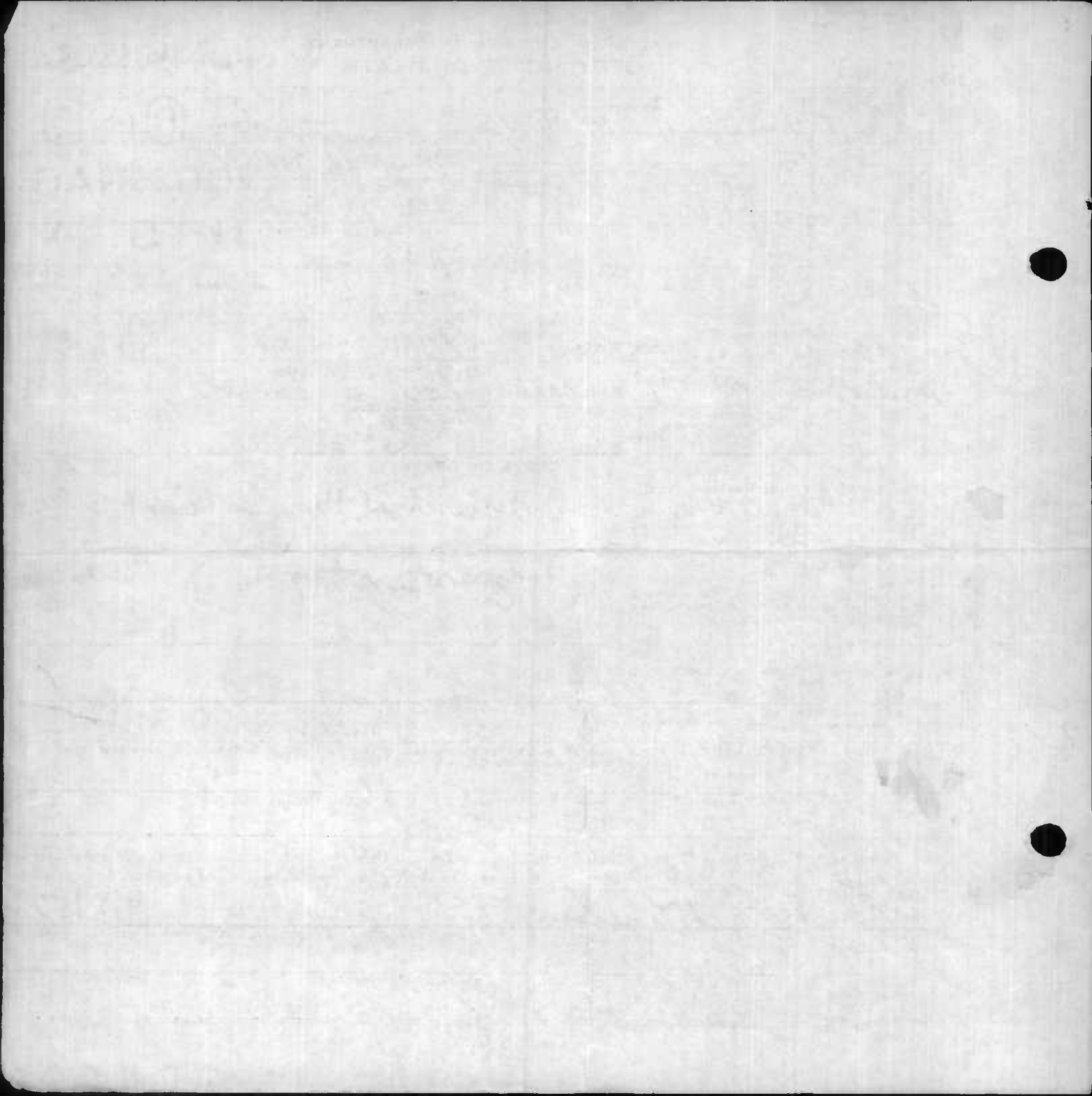
H. J. Williams M.D.

25. FUNERAL DIRECTOR

L. J. Ruck

ADDRESS

1305 Harford Rd



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>53 7007</u>	
BIRTH NO. <u>53 700753-16780</u> <b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <u>PATRICIA ANN KEHRING</u>				2. DATE OF DEATH <u>8/2/53</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1-04</u>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>MERCY HOSPITAL</u>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>BALTIMORE</u>	
c. Length of stay in Baltimore <u>13</u> Yrs. Mos. Days				D. STREET ADDRESS (If rural, give location) <u>507 S. Madeira St.</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>		8. DATE OF BIRTH <u>7/20/53</u>	9. AGE (In years, last birthday) <u>13</u> Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>INFANT</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John H. Kehring Jr.</u>	
14. MOTHER'S MAIDEN NAME <u>Doris May SCHUNCK</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT ADDRESS <u>JOHN H. KEHRING JR. SAME</u>	
18. <u>754.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Congenital Heart Malformation</u> DUE TO (A) <u>Congenital Heart Malformation</u> (B) <u></u> (C) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>7</u>		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8/1</u> , 19 <u>53</u> , to <u>8/2</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>7/2</u> , 19 <u>53</u> , and that death occurred at <u>9:55 A.M.</u> , from the causes and on the date stated above.					
23A. SIGNATURE <u>Joseph F. Palmisano</u>		23B. ADDRESS <u>Mercy Hospital</u>		23C. DATE SIGNED <u>8/2/53</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8-3-53</u>		24C. NAME OF CEMETERY OR CREMATORY <u>SCHWARTZ'S CEM.</u>	
24D. LOCATION (City, town, or county) (State) <u>O'DONNELL ST. BALTO. MD.</u>		24E. DATE RECEIVED BY LOCAL REGISTRAR <u>AUG 3 1953</u>		24F. REGISTRAR'S SIGNATURE <u>Charles J. Seiler</u>	
24G. FUNERAL DIRECTOR <u>Charles J. Seiler</u>		24H. ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u>		24I. VS 150	

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE CITY AND COUNTY OF NEW YORK

DECEASED

NAME

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of Mayor

Signature of City Clerk

Signature of County Clerk

Signature of District Attorney

Signature of District Attorney

Signature of District Attorney

Signature of District Attorney

Signature of District Attorney

Signature of District Attorney

Signature of District Attorney

Signature of District Attorney

Signature of District Attorney

Signature of District Attorney

Signature of District Attorney

Signature of District Attorney

Signature of District Attorney

Signature of District Attorney

Signature of District Attorney

Signature of District Attorney

Signature of District Attorney



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

53 7008  
Registered No. 3698

BIRTH NO.

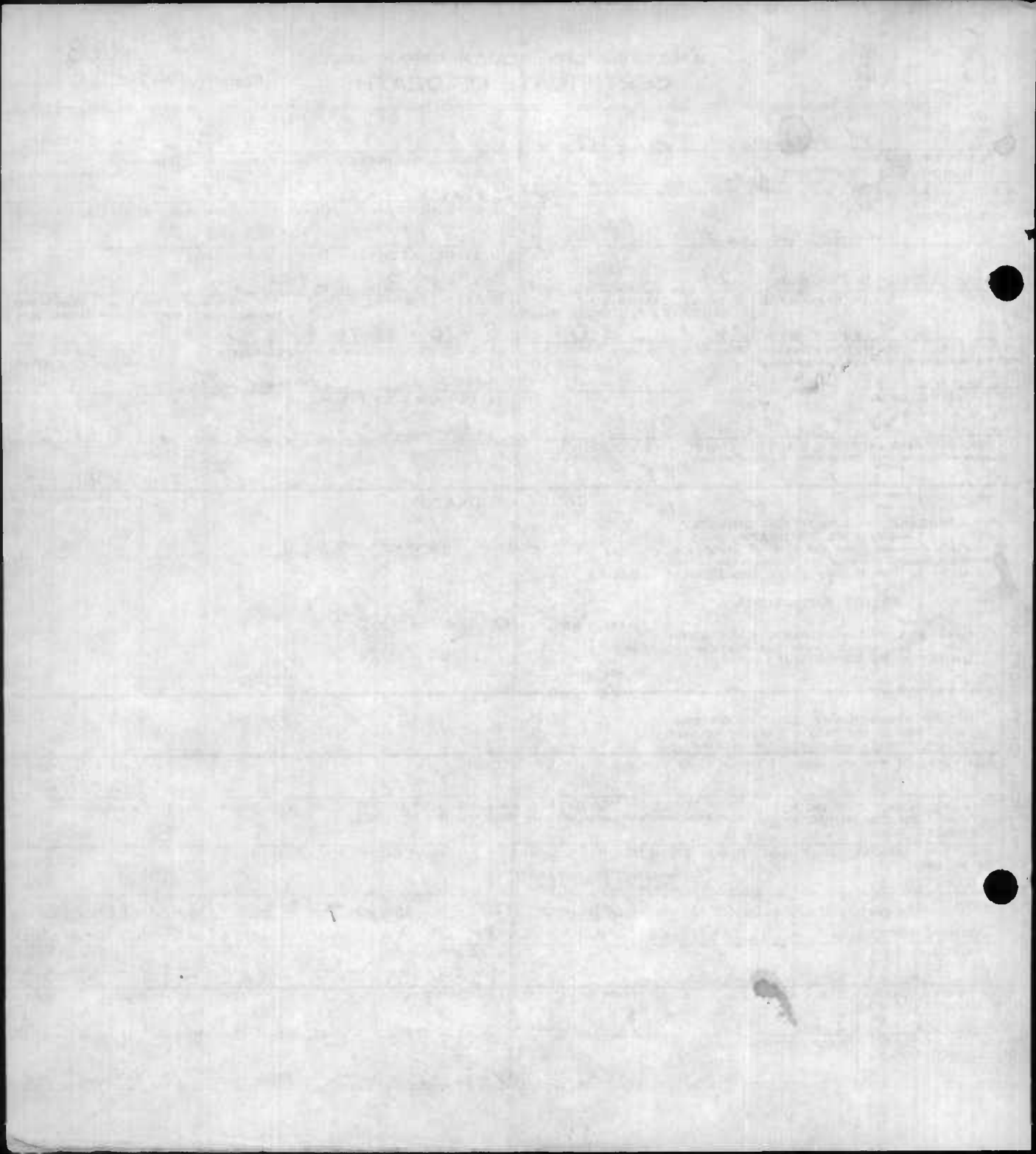
1. NAME OF DECEASED (Type or Print) <u>Hester Thornton</u>		2. DATE OF DEATH <u>7-29-53</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Balt. Md</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>12-02</u>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>1419 Brunt St.</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Balto. City</u>	
Length of stay in Baltimore <u>21 yrs</u> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <u>1419 Brunt ST.</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>8-16-1890</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>62</u>
13. FATHER'S NAME <u>John Whitfield N.C.</u>		11. BIRTHPLACE (State or foreign country) <u>Indian Wood N.C.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <u>Sarah Williams N.C.</u>	
17. INFORMANT <u>Wm. Thornton St.</u>		ADDRESS <u>2448 Ething St.</u>	

18. <u>331X</u> I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <u>Cerebral hemorrhage</u>		<u>2 mo</u>	
DUE TO					
ANTECEDENT CAUSES		(B) <u>Arterio Sclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 6-22-, 1953 to 7-29-, 1953 that I last saw the deceased alive on 7-29-, 1953 and that death occurred at 2:45 P.m., from the causes and on the date stated above.

23A. SIGNATURE <u>Frank A. Saunders</u>		23B. ADDRESS <u>1029 N. Strayer St.</u>		23C. DATE SIGNED <u>8-3-53</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-3-53</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>	
24D. LOCATION (City, town, or county) <u>A. A. County Md.</u>		25. FUNERAL DIRECTOR <u>Wm. G. Jackson</u>		ADDRESS <u>916 Penn. Ave.</u>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>Hester Thornton</u>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

R-200  
53 7009

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7009  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary Roach

2. DATE  
OF  
DEATH

July-31-1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Order 4

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

10

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

16 S. Bethel St

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

8-28-94

9. AGE (In years last birthday)

58

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Fred Thomas

14. MOTHER'S MAIDEN NAME

Ethel Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18. 521 X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Lung Abscess, Empyema

4 mo.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

aspirational pneumonia  
Epilepsy.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-9, 1953, to 7-31, 1953, that I last saw the deceased alive on 7-31, 1953 and that death occurred at 7:15 p.m., from the causes and on the date stated above.

23A. SIGNATURE

W.S. Matthews

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

7/31/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug 4/53

24C. NAME OF CEMETERY OR CREMATORY

Int. Calvary Cems

24D. LOCATION (City, town, or county)

A.A. County, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Mrs. Robert A. Christ & Daughter

11297 Caroline St.

12

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **53 7010**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM

CHEEKS

2. DATE OF DEATH  
**July 29, 1953**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  
**South Baltimore General Hospital**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
**Maryland**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore**

D. STREET ADDRESS (If rural, give location)  
**38 Hugh St**

c. Length of stay in Baltimore

5. SEX  
**male**

6. COLOR OR RACE  
**colored**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
**Widower**

8. DATE OF BIRTH  
**May 1, 1903**

9. AGE (In years last birthday)  
**50**

If Under 1 Year Months Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
**Unemp. Laborer**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)  
**Portsmouth Va.**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME  
**William Cheeks Sr.**

14. MOTHER'S MAIDEN NAME  
**unknown**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
**no**

16. SOCIAL SECURITY NO.

17. INFORMANT  
**Vernie Harrison**

ADDRESS  
**908 Rutledge**

18. **581.1**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
**Fatty metamorphosis of liver**

(A) **XXXX**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
**Pulmonary edema**

(B) **XXXX**

(C) **Chronic Alcoholism**

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: **natural causes** ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE  
**Joseph A. Jachimczyk**

M.D.

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED  
**7-30-53**

24A. BURIAL, CREATION, REMOVAL (Specify)  
**Burial**

24B. DATE  
**Aug. 1953**

24C. NAME OF CEMETERY OR CREMATORY  
**Mt. Calvary Cemo.**

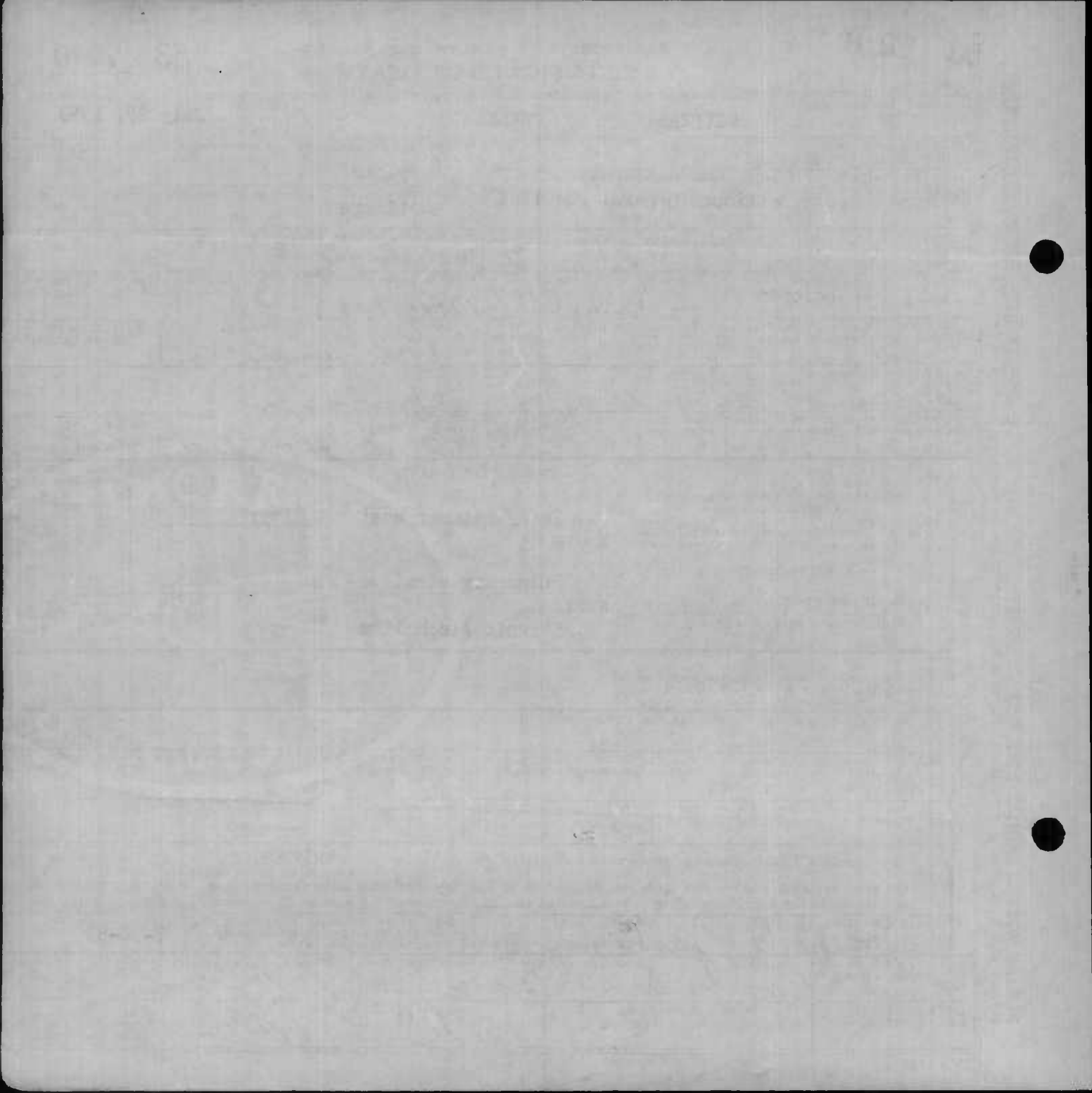
24D. LOCATION (City, town, or county) (State)  
**A.A. County Md.**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE  
**[Signature]**

25. FUNERAL DIRECTOR  
**Mrs. Ernest A. White & Sons**

ADDRESS





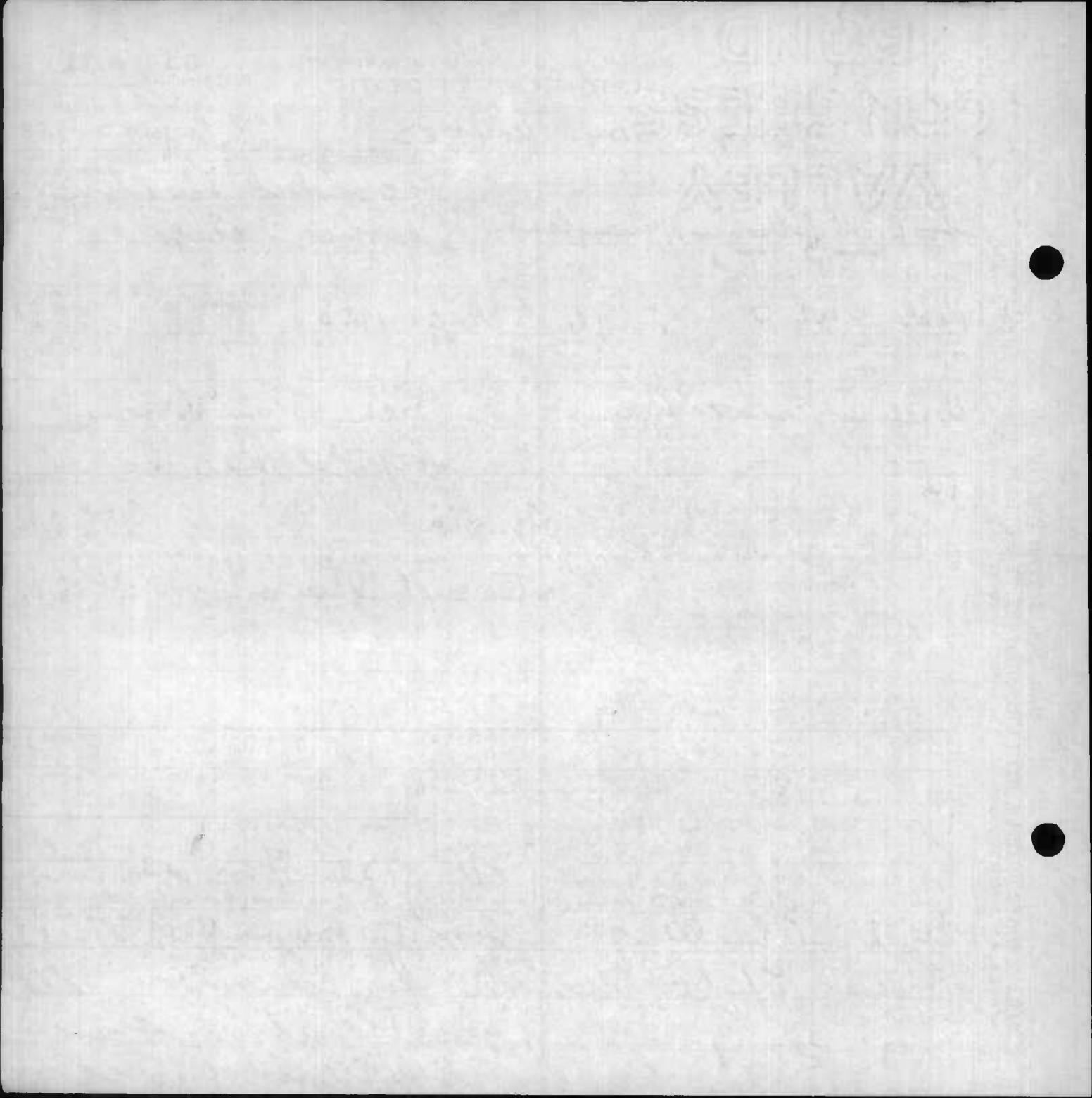
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-620  
53 7011  
BIRTH NO. 53-19797

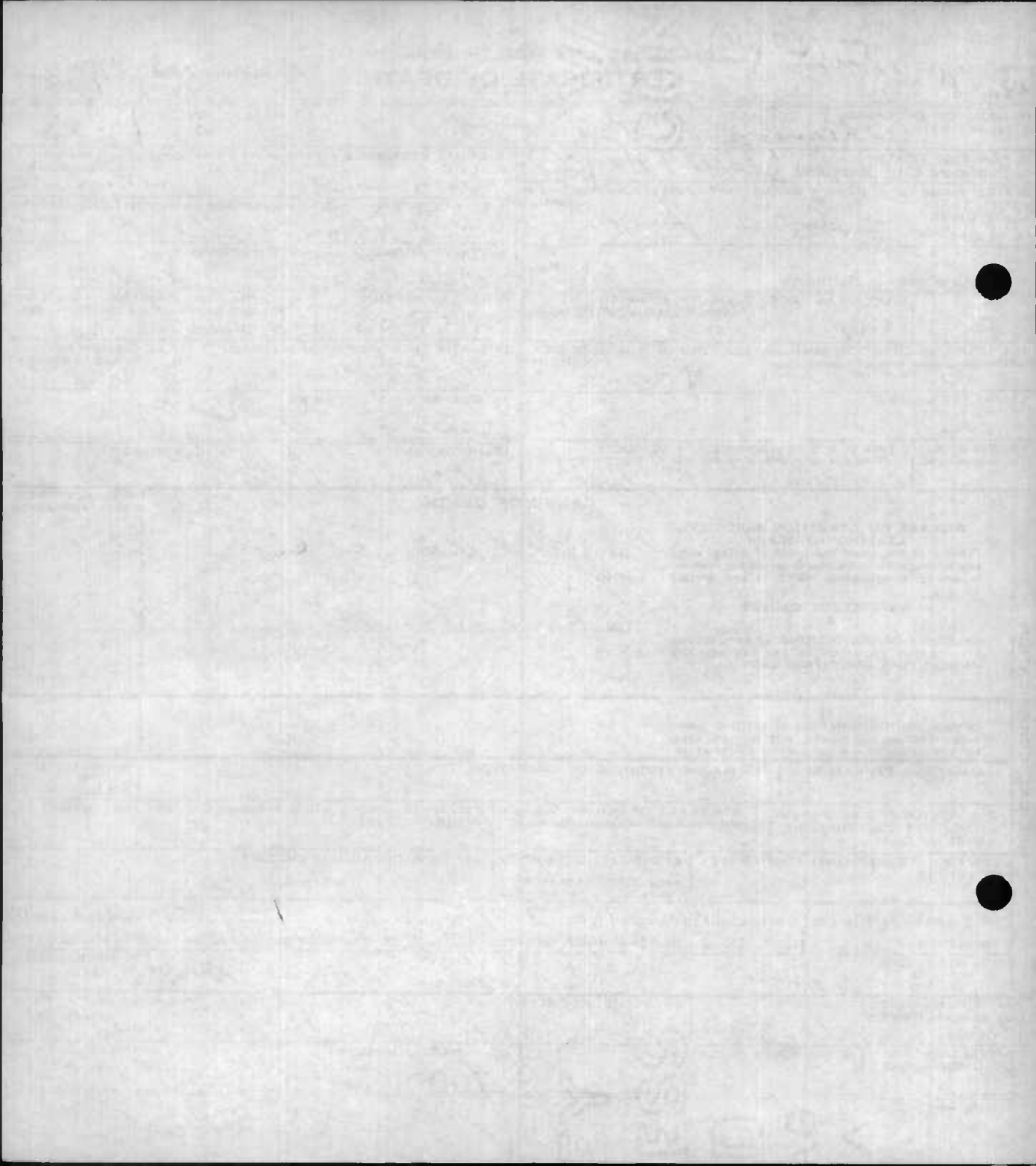
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7011  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>BOBBY BOY MYERS</b>		2. DATE OF DEATH <b>August 2 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Luke's Talbot Memorial of Maryland</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Overmyer Mills</b>	
D. STREET ADDRESS (If rural, give location) <b>5200</b>			
c. Length of stay in Baltimore Yrs. <b>0</b> Mos. <b>0</b> Days <b>0</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W.C.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Aug 1, 1953</b>
9. AGE (In years last birthday) <b>38 5/1</b>		10. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. FATHER'S NAME <b>William Ernest Myers</b>		12. MOTHER'S MAIDEN NAME <b>Gene Van Jones</b>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>—</b>		14. SOCIAL SECURITY NO. <b>—</b>	
15. INFORMANT <b>Hospital Records</b>		ADDRESS <b>—</b>	
16. 760.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Anoxia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>38 1/2-5/14</b>	
17. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Intra cerebral Pen on Legs</b>		DUE TO <b>38 1/2-5/14</b>	
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>			
19A. DATE OF OPERATION <b>8/1</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>	
21C. WHERE DID INJURY OCCUR? <b>—</b>		21D. HOW DID INJURY OCCUR? <b>—</b>	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <b>8/1</b> , 19 <b>53</b> , to <b>8/2</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>8/2</b> , 19 <b>53</b> , and that death occurred at <b>7 P.m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>William Ernest Myers</b>		23B. ADDRESS <b>St. Luke's Talbot Memorial 840</b>	
23C. DATE SIGNED <b>8/2/53</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>General</b>		24B. DATE <b>8/3/53</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Methodist Cem. Chincoutown, Md.</b>		24D. LOCATION (City, town, or county) (State) <b>New Windsor, Md.</b>	
25. FUNERAL DIRECTOR <b>W.D. Hartley &amp; Sons</b>		ADDRESS <b>—</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>8/5/53</b>		REGISTRAR'S SIGNATURE <b>—</b>	



BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No.	
A-352 701253-15876		Pamela Dorothy				Aug. 7 <sup>th</sup> 1953	
1. NAME OF DECEASED (Type or Print) <i>Atkinson Baby girl</i>				2. DATE OF DEATH <i>8/2/53</i>			
3. PLACE OF DEATH: a. Baltimore City, Maryland <i>Church &amp; Home Hosp.</i>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. FULL NAME OF HOSPITAL OR INSTITUTION <i>Church &amp; Home Hosp.</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>3708 Yolanda Rd.</i>			
c. Birth of stay in Baltimore <i>26</i> Yrs. Mos. Days				d. STREET ADDRESS (If rural, give location) <i>Baltimore, Md. 9-03</i>			
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE / MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>7-7-53</i>	9. AGE (in years last birthday) <i>26 days</i>	If Under 1 Year: Months: Days; If Under 24 Hours: Hours: Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>child</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Thomas</i>		14. MOTHER'S MAIDEN NAME <i>Bull. Dorothy</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>None</i>			
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Thomas Atkinson</i>		18. ADDRESS <i>3708 Yolanda Rd.</i>			
18. <i>776x</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
(A) <i>Prematurity</i>		DUE TO		<i>all life</i>			
ANTECEDENT CAUSES		(B) <i>None</i>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO					
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19a. DATE OF OPERATION <i>7</i>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>7-7</i> , 1953 to <i>8-2</i> , 1953, that I last saw the deceased alive on <i>8-1</i> , 1953, and that death occurred at <i>7 A.m.</i> , from the causes and on the date stated above.							
23a. SIGNATURE <i>J. Nouri</i>		23b. ADDRESS <i>Church &amp; Home Hosp.</i>		23c. DATE SIGNED <i>8-3-53</i>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		24b. DATE <i>Aug 3 1953</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Greenwood Cemetery</i>		24d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>953000</i>		25. FUNERAL DIRECTOR <i>Harry Bayne &amp; Son, Inc</i>		ADDRESS <i>Baltimore Md</i>	

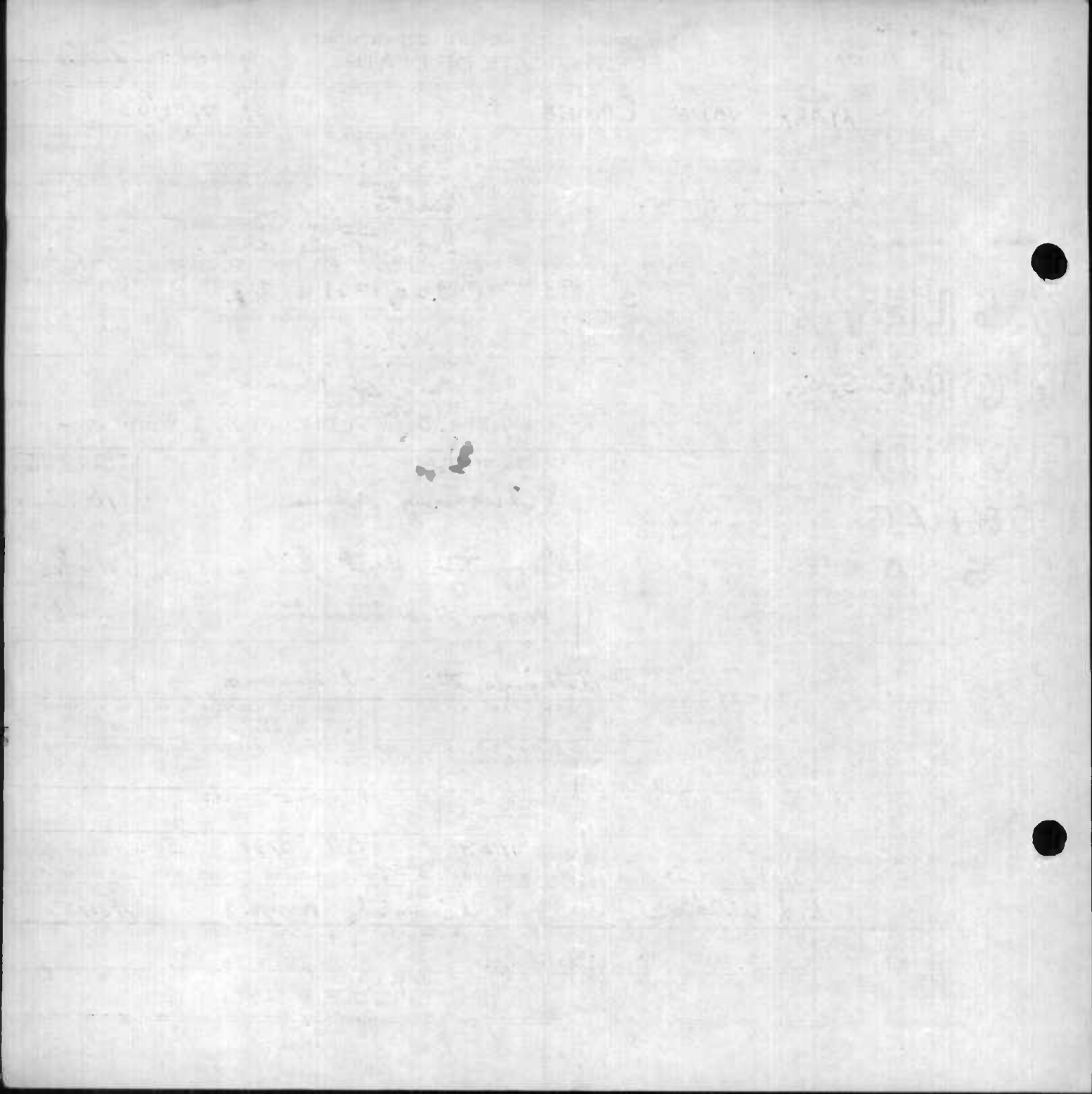


S. 126  
53 7013  
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7013

1. NAME OF DECEASED (Type or Print) <b>MARY JANE SPICER</b>			2. DATE OF DEATH <b>7/31/53</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>University Hosp.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto.</b>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>3002 Taylor Ave. 5200</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Oct. 20, 1871</b>	9. AGE (in years last birthday) <b>81</b>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk B. &amp; O. R.R.</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Caleb Spicer</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Brown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Mrs. Emma Felber 3002 Taylor Ave-14</b>		
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary edema</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Congestive heart failure</b>			DUE TO <b>Myocardial infarction</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Arteriosclerotic C-V disease</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7/28</b> , 19 <b>53</b> , to <b>7/31</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>7/31</b> , 19 <b>53</b> , and that death occurred at <b>3:45 P.</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>A. H. Wenier</b>		23B. ADDRESS <b>University Hosp.</b>		23C. DATE SIGNED <b>7/31/53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 3. 1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>		25. FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS, INC.</b>		ADDRESS <b>Baltimore Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		VS 150	

*Henry P. Sander*





2-640

53 7014

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7014

1. NAME OF DECEASED (Type or Print) <b>ANNIE V. CARLE</b>		2. DATE OF DEATH <b>Aug 1-1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>271 S. Stricker St</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 19-9-3</b>	
D. STREET ADDRESS (If rural, give location) <b>271 S. Stricker St</b>		E. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>Sept 24, 1872</b>
9. AGE (In years, last birthday) <b>80</b>		10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>BALTO md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Anthony Zimmermann</b>		14. MOTHER'S MAIDEN NAME <b>ANNA POLLACK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NO ONE</b>	
17. INFORMANT <b>ANN M. BANNAN</b>		ADDRESS <b>271 S. Stricker St</b>	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Hypertensive, arteriosclerotic cardiovascular disease</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7-27-53</b> , 19__, to <b>8-1-53</b> , 19__, that I last saw the deceased alive on <b>7-31-53</b> , 19__, and that death occurred at <b>5 P. m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Nathan Racusin</b>		23B. ADDRESS <b>206 S. Gilman St</b>	
23C. DATE SIGNED <b>8-3-53</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8-4-1953</b>	24C. NAME OF CEMETERY OR CREMATORY <b>London Park</b>	24D. LOCATION (City, town, or county) (State) <b>Balto md</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 3 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>	
VS 150		FUNERAL DIRECTOR <b>Pratt &amp; Stricker</b>	

MEDICAL CERTIFICATION

CALIFORNIA DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. PLACE OF DEATH	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESS		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JUDGE	
16. SIGNATURE OF CLERK		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF SHERIFF		19. SIGNATURE OF SHERIFF'S CLERK		20. SIGNATURE OF SHERIFF'S DEPUTY	
21. SIGNATURE OF SHERIFF'S DEPUTY		22. SIGNATURE OF SHERIFF'S DEPUTY		23. SIGNATURE OF SHERIFF'S DEPUTY		24. SIGNATURE OF SHERIFF'S DEPUTY		25. SIGNATURE OF SHERIFF'S DEPUTY	
26. SIGNATURE OF SHERIFF'S DEPUTY		27. SIGNATURE OF SHERIFF'S DEPUTY		28. SIGNATURE OF SHERIFF'S DEPUTY		29. SIGNATURE OF SHERIFF'S DEPUTY		30. SIGNATURE OF SHERIFF'S DEPUTY	
31. SIGNATURE OF SHERIFF'S DEPUTY		32. SIGNATURE OF SHERIFF'S DEPUTY		33. SIGNATURE OF SHERIFF'S DEPUTY		34. SIGNATURE OF SHERIFF'S DEPUTY		35. SIGNATURE OF SHERIFF'S DEPUTY	
36. SIGNATURE OF SHERIFF'S DEPUTY		37. SIGNATURE OF SHERIFF'S DEPUTY		38. SIGNATURE OF SHERIFF'S DEPUTY		39. SIGNATURE OF SHERIFF'S DEPUTY		40. SIGNATURE OF SHERIFF'S DEPUTY	
41. SIGNATURE OF SHERIFF'S DEPUTY		42. SIGNATURE OF SHERIFF'S DEPUTY		43. SIGNATURE OF SHERIFF'S DEPUTY		44. SIGNATURE OF SHERIFF'S DEPUTY		45. SIGNATURE OF SHERIFF'S DEPUTY	
46. SIGNATURE OF SHERIFF'S DEPUTY		47. SIGNATURE OF SHERIFF'S DEPUTY		48. SIGNATURE OF SHERIFF'S DEPUTY		49. SIGNATURE OF SHERIFF'S DEPUTY		50. SIGNATURE OF SHERIFF'S DEPUTY	
51. SIGNATURE OF SHERIFF'S DEPUTY		52. SIGNATURE OF SHERIFF'S DEPUTY		53. SIGNATURE OF SHERIFF'S DEPUTY		54. SIGNATURE OF SHERIFF'S DEPUTY		55. SIGNATURE OF SHERIFF'S DEPUTY	
56. SIGNATURE OF SHERIFF'S DEPUTY		57. SIGNATURE OF SHERIFF'S DEPUTY		58. SIGNATURE OF SHERIFF'S DEPUTY		59. SIGNATURE OF SHERIFF'S DEPUTY		60. SIGNATURE OF SHERIFF'S DEPUTY	
61. SIGNATURE OF SHERIFF'S DEPUTY		62. SIGNATURE OF SHERIFF'S DEPUTY		63. SIGNATURE OF SHERIFF'S DEPUTY		64. SIGNATURE OF SHERIFF'S DEPUTY		65. SIGNATURE OF SHERIFF'S DEPUTY	
66. SIGNATURE OF SHERIFF'S DEPUTY		67. SIGNATURE OF SHERIFF'S DEPUTY		68. SIGNATURE OF SHERIFF'S DEPUTY		69. SIGNATURE OF SHERIFF'S DEPUTY		70. SIGNATURE OF SHERIFF'S DEPUTY	
71. SIGNATURE OF SHERIFF'S DEPUTY		72. SIGNATURE OF SHERIFF'S DEPUTY		73. SIGNATURE OF SHERIFF'S DEPUTY		74. SIGNATURE OF SHERIFF'S DEPUTY		75. SIGNATURE OF SHERIFF'S DEPUTY	
76. SIGNATURE OF SHERIFF'S DEPUTY		77. SIGNATURE OF SHERIFF'S DEPUTY		78. SIGNATURE OF SHERIFF'S DEPUTY		79. SIGNATURE OF SHERIFF'S DEPUTY		80. SIGNATURE OF SHERIFF'S DEPUTY	
81. SIGNATURE OF SHERIFF'S DEPUTY		82. SIGNATURE OF SHERIFF'S DEPUTY		83. SIGNATURE OF SHERIFF'S DEPUTY		84. SIGNATURE OF SHERIFF'S DEPUTY		85. SIGNATURE OF SHERIFF'S DEPUTY	
86. SIGNATURE OF SHERIFF'S DEPUTY		87. SIGNATURE OF SHERIFF'S DEPUTY		88. SIGNATURE OF SHERIFF'S DEPUTY		89. SIGNATURE OF SHERIFF'S DEPUTY		90. SIGNATURE OF SHERIFF'S DEPUTY	
91. SIGNATURE OF SHERIFF'S DEPUTY		92. SIGNATURE OF SHERIFF'S DEPUTY		93. SIGNATURE OF SHERIFF'S DEPUTY		94. SIGNATURE OF SHERIFF'S DEPUTY		95. SIGNATURE OF SHERIFF'S DEPUTY	
96. SIGNATURE OF SHERIFF'S DEPUTY		97. SIGNATURE OF SHERIFF'S DEPUTY		98. SIGNATURE OF SHERIFF'S DEPUTY		99. SIGNATURE OF SHERIFF'S DEPUTY		100. SIGNATURE OF SHERIFF'S DEPUTY	

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7015  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE W. BUDOLPH Also BOTHOFF

2. DATE  
OF  
DEATH

August 1, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR VA HOSPITAL  
INSTITUTION BALTIMORE 18 MD.4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE MARYLAND  
B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
BALTIMORE 17-04D. STREET ADDRESS (If rural, give location)  
337 S. FULTON AVE.

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

Yrs.  
MOS.  
Days

8. DATE OF BIRTH

12/19/84

9. AGE (In years  
last birthday)

68

If Under 1 Year  
Months Days  
If Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

HUCHSTER

10B. KIND OF BUSINESS OR  
INDUSTRY

FRUITS &amp; VEGETABLES

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

GEORGE BOTHOFF

14. MOTHER'S MAIDEN NAME

EICHBERGER

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

9/9/18 -1/6/19

16. SOCIAL  
SECURITY NO.

Unknown

17. INFORMANT

ADDRESS

VA HOSPITAL RECORDS VAH BALTIMORE, MD.

18.

002X

CAUSE OF DEATH

TUBERCULOSIS PULMONARY BILATERAL

FAR ADVANCED

INTERVAL BETWEEN  
ONSET AND DEATH

20 yrs

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

PULMONARY EMPHYSEMA

UNKNOWN

19A. DATE OF OPERATION

NONE

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

VA

m.

21E. INJURY OCCURRED

WHILE AT ☐  
WORKNOT WHILE ☐  
AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/26/53, 19, to 8/1/53, 19, that I last saw the  
deceased alive on 7/26/53, 19, and that death occurred at 11:55 AM from the causes and on the date stated above.

23A. SIGNATURE

Bruce Armstrong

23B. ADDRESS

M. D.

VAH BALTIMORE 18 MD.

23C. DATE SIGNED

8/1/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

Aug. 4/53

24C. NAME OF CEMETERY OR CREMATORY

Landon Pk. Baltimore

24D. LOCATION (City, town, or county) (State)

Baltimore Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

430 6A

ave

# CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

UNITED STATES OF AMERICA

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. MARITAL STATUS</p>		<p>8. DATE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>		<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. PLACE OF DEATH</p>		<p>14. TIME OF DEATH</p>		<p>15. SIGNATURE OF WITNESS</p>		<p>16. SIGNATURE OF DECEASED</p>	
<p>17. SIGNATURE OF DECEASED</p>		<p>18. SIGNATURE OF DECEASED</p>		<p>19. SIGNATURE OF DECEASED</p>		<p>20. SIGNATURE OF DECEASED</p>	
<p>21. SIGNATURE OF DECEASED</p>		<p>22. SIGNATURE OF DECEASED</p>		<p>23. SIGNATURE OF DECEASED</p>		<p>24. SIGNATURE OF DECEASED</p>	
<p>25. SIGNATURE OF DECEASED</p>		<p>26. SIGNATURE OF DECEASED</p>		<p>27. SIGNATURE OF DECEASED</p>		<p>28. SIGNATURE OF DECEASED</p>	
<p>29. SIGNATURE OF DECEASED</p>		<p>30. SIGNATURE OF DECEASED</p>		<p>31. SIGNATURE OF DECEASED</p>		<p>32. SIGNATURE OF DECEASED</p>	
<p>33. SIGNATURE OF DECEASED</p>		<p>34. SIGNATURE OF DECEASED</p>		<p>35. SIGNATURE OF DECEASED</p>		<p>36. SIGNATURE OF DECEASED</p>	
<p>37. SIGNATURE OF DECEASED</p>		<p>38. SIGNATURE OF DECEASED</p>		<p>39. SIGNATURE OF DECEASED</p>		<p>40. SIGNATURE OF DECEASED</p>	
<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF DECEASED</p>		<p>43. SIGNATURE OF DECEASED</p>		<p>44. SIGNATURE OF DECEASED</p>	
<p>45. SIGNATURE OF DECEASED</p>		<p>46. SIGNATURE OF DECEASED</p>		<p>47. SIGNATURE OF DECEASED</p>		<p>48. SIGNATURE OF DECEASED</p>	
<p>49. SIGNATURE OF DECEASED</p>		<p>50. SIGNATURE OF DECEASED</p>		<p>51. SIGNATURE OF DECEASED</p>		<p>52. SIGNATURE OF DECEASED</p>	
<p>53. SIGNATURE OF DECEASED</p>		<p>54. SIGNATURE OF DECEASED</p>		<p>55. SIGNATURE OF DECEASED</p>		<p>56. SIGNATURE OF DECEASED</p>	
<p>57. SIGNATURE OF DECEASED</p>		<p>58. SIGNATURE OF DECEASED</p>		<p>59. SIGNATURE OF DECEASED</p>		<p>60. SIGNATURE OF DECEASED</p>	
<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF DECEASED</p>		<p>63. SIGNATURE OF DECEASED</p>		<p>64. SIGNATURE OF DECEASED</p>	
<p>65. SIGNATURE OF DECEASED</p>		<p>66. SIGNATURE OF DECEASED</p>		<p>67. SIGNATURE OF DECEASED</p>		<p>68. SIGNATURE OF DECEASED</p>	
<p>69. SIGNATURE OF DECEASED</p>		<p>70. SIGNATURE OF DECEASED</p>		<p>71. SIGNATURE OF DECEASED</p>		<p>72. SIGNATURE OF DECEASED</p>	
<p>73. SIGNATURE OF DECEASED</p>		<p>74. SIGNATURE OF DECEASED</p>		<p>75. SIGNATURE OF DECEASED</p>		<p>76. SIGNATURE OF DECEASED</p>	
<p>77. SIGNATURE OF DECEASED</p>		<p>78. SIGNATURE OF DECEASED</p>		<p>79. SIGNATURE OF DECEASED</p>		<p>80. SIGNATURE OF DECEASED</p>	
<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF DECEASED</p>		<p>83. SIGNATURE OF DECEASED</p>		<p>84. SIGNATURE OF DECEASED</p>	
<p>85. SIGNATURE OF DECEASED</p>		<p>86. SIGNATURE OF DECEASED</p>		<p>87. SIGNATURE OF DECEASED</p>		<p>88. SIGNATURE OF DECEASED</p>	
<p>89. SIGNATURE OF DECEASED</p>		<p>90. SIGNATURE OF DECEASED</p>		<p>91. SIGNATURE OF DECEASED</p>		<p>92. SIGNATURE OF DECEASED</p>	
<p>93. SIGNATURE OF DECEASED</p>		<p>94. SIGNATURE OF DECEASED</p>		<p>95. SIGNATURE OF DECEASED</p>		<p>96. SIGNATURE OF DECEASED</p>	
<p>97. SIGNATURE OF DECEASED</p>		<p>98. SIGNATURE OF DECEASED</p>		<p>99. SIGNATURE OF DECEASED</p>		<p>100. SIGNATURE OF DECEASED</p>	





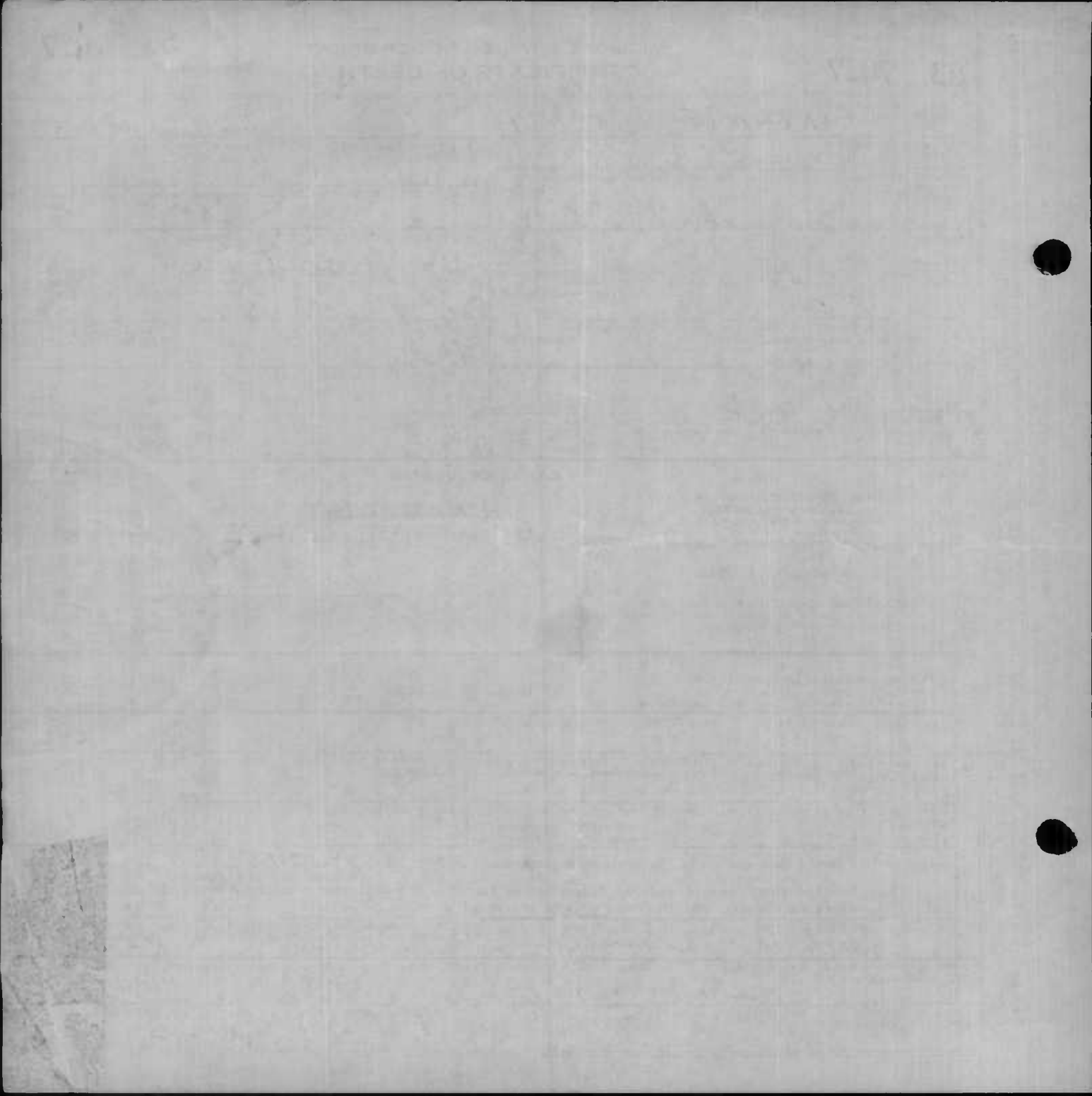


PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7017  
Registered No.

5-530 53 7017 BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MINNIE SMITH</b>		2. DATE OF DEATH <b>Aug 1st 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>W.D.C. Hopkins</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md</b>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospt. W.D.C.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto</b>			
C. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>298 W. Balas Court</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Oct 16<sup>th</sup> 1889</b>		9. AGE (In years last birthday) <b>63</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md</b>	
13. FATHER'S NAME <b>Joseph Hart</b>		14. MOTHER'S MAIDEN NAME <b>—</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Wm Smith 298 W. Balas Court</b>	
18. <b>581.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Fatty metamorphosis of liver</b>		CAUSE OF DEATH <b>XX Fatty metamorphosis of liver</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Pulmonary edema</b>		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED M. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <b>AUTOPSY</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>Joseph A. Jachimczyk</b> M.D.		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <b>8-2-53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Aug 4<sup>th</sup> 1953</b>		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <b>St. Matthews</b>	
24D. LOCATION (City, town, or county) (State) <b>MD Donnel St. Ext.</b>		25. FUNERAL DIRECTOR <b>Leah Cook 1703 N. Park Park Ave</b>		ADDRESS	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

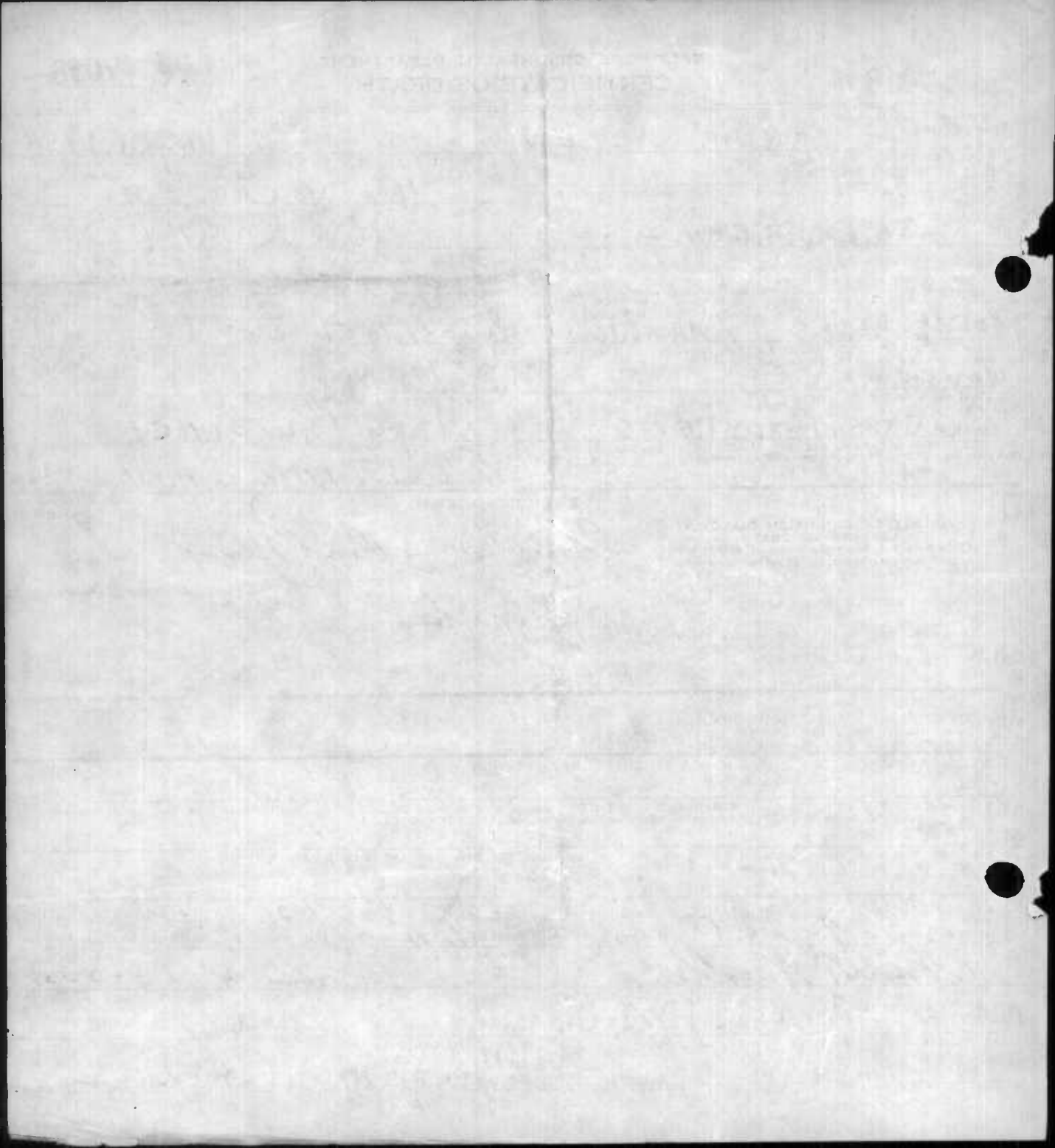
553 7018  
Registered No. 7018

53 7018  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ANNIE ALLEN</b>		2. DATE OF DEATH <b>July 31, 1953</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MD</b> b. COUNTY <b>116 W CROSS ST</b>	
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>So. BALTO. GEN. HOSP.</b>		c. CITY OR TOWN <b>Balto. Md</b>	
Length of stay in Baltimore <b>15</b> Yrs. Mos. Days		d. STREET ADDRESS (If rural, give location) <b>116 W. Cross St.</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>Aug 31, 1887</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years, last birthday) <b>65</b>
13. FATHER'S NAME <b>Sutton Spriggs</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO. <b>213-10-3155</b>		14. MOTHER'S MAIDEN NAME <b>Mary LAWRENCE</b>	
17. INFORMANT <b>Clarence H. Allen Jr</b>		ADDRESS <b>116 W Cross St.</b>	

18. <b>442X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebro Vascular Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7</b>
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Hypertension</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19a. DATE OF OPERATION <b>0</b>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>7-28, 1953</b> to <b>7-31, 1953</b> , that I last saw the deceased alive on <b>7-29, 1953</b> , and that death occurred at <b>4 A.M.</b> , from the causes and on the date stated above.				
23a. SIGNATURE <b>Charles T. Woodley</b>		23b. ADDRESS <b>861 1st Ave NW</b>		23c. DATE SIGNED <b>8-2-53</b>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>Aug 4-53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>	24d. LOCATION (City, town, or county) (State) <b>Balto</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 3 1953</b>	REGISTRAR'S SIGNATURE <b>W. B. Spriggs</b>	25. FUNERAL DIRECTOR ADDRESS <b>139 W. Hanley St</b>		



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. **53 7019**

BIRTH NO. **53 7019**

1. NAME OF DECEASED (Type or Print) <b>Nicholas L. Spinelli</b>			2. DATE OF DEATH <b>Aug. 2, 1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Med. Hosp.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 28</b>		
c. Length of stay in Baltimore <b>2 WK</b>			D. STREET ADDRESS (If rural, give location) <b>2120 Arlanne Drive</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>10-28-12</b>		9. AGE (In years last birthday) <b>40</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mech. Eng.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Rice Bakery</b>		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>	
13. FATHER'S NAME <b>Lawrence Spinelli</b>			14. MOTHER'S MAIDEN NAME <b>Ciotoli</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>200-03-0406</b>		17. INFORMANT ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>	

18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarct.</b>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>acute coronary occlusion.</b>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>7-21-53</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7-21-53</b> to <b>8-2-53</b> , that I last saw the deceased alive on <b>8-2-53</b> and that death occurred at <b>10:20 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Ed Brakehut</b>		23B. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>		23C. DATE SIGNED <b>8.2.53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 6, 1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Blairsville, Pa.</b>	
24D. LOCATION (City, town, or county) (State) <b>Blairsville, Pa.</b>		25. FUNERAL DIRECTOR <b>Spae Habb &amp; Son</b>		ADDRESS <b>Catonville, Md.</b>	

Highly confidential  
Mr. White  
Dear Mr. White  
I am very glad to hear  
from you and hope you are  
well.

Very truly  
yours  
J. Edgar Hoover

12.5.71  
J. Edgar Hoover



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

THOMAS

CUMMINGS

2. DATE  
OF  
DEATH

July 29, 1953

53 7020  
Registered No.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (not in hospital or institution, give street address or location)

South Baltimore General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

407 E. Heaver Street

c. Length of stay in Baltimore

Left

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

1-8-1940

9. AGE (In years last birthday)

13

10. Under 1 Year  
Months Days11. Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Anders Cummings

14. MOTHER'S MAIDEN NAME

Anne Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Anne Wright 427 Heaver St

18. E929.8

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Drowning

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Harbor

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Hanover Street Bridge

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

July 29, 1953 1:30 P.m.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Drowned while trying to swim

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R. F. Fisher

23B. CHIEF MEDICAL EXAMINER.....☒ ASSISTANT MEDICAL EXAMINER.....☐ MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

July 29, 1953

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-3-53

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary Cem A A Co

24D. LOCATION (City, town, or county)

(State)

md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington

25. FUNERAL DIRECTOR

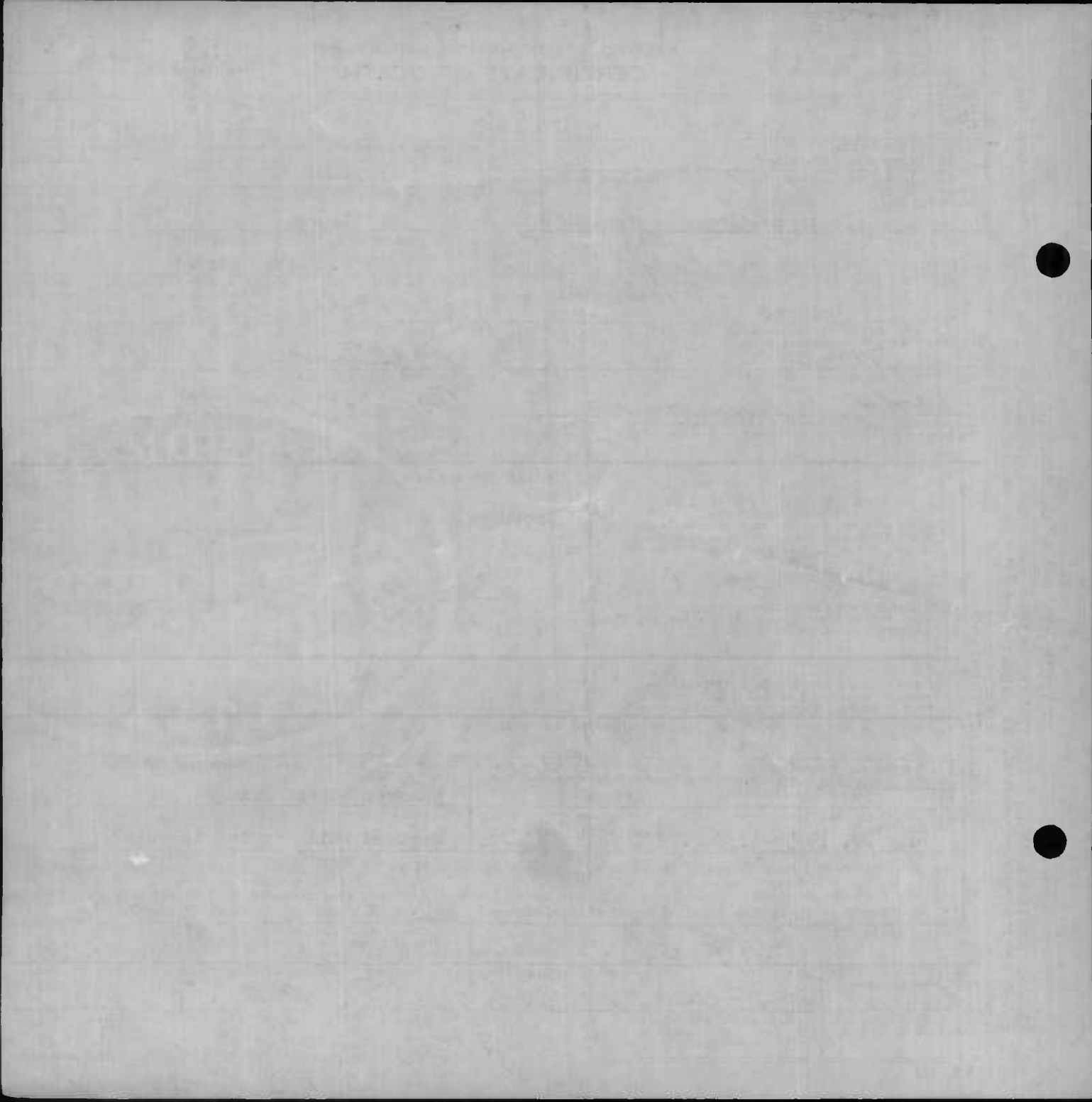
C. B. Sanders

ADDRESS

217 E. Preston St

VS 151

N990X



5-522  
53 7021SZYM KOWIAK  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7021  
Registered No.

BIRTH NO. 25 265		2. DATE OF DEATH Aug. 2, 53	
1. NAME OF DECEASED (Type or Print) (SCHIRM) Frank Szymkowiak		7. DATE OF DEATH	
3. PLACE OF DEATH: A. Baltimore City, Maryland Coter 602		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) Ind.	
B. FULL NAME OF (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore - 1-05	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 406 S. Madeira St.	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 8-15-97
9. AGE (In years last birthday) 56	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer	10B. KIND OF BUSINESS OR INDUSTRY Printing	9. AGE (In years last birthday) 56
11. BIRTHPLACE (State or foreign country) Balto. Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A	14. MOTHER'S MAIDEN NAME L	
13. FATHER'S NAME John Szymkowiak	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 212-09-9631	17. INFORMANT JOHNS HOPKINS HOSPITAL		

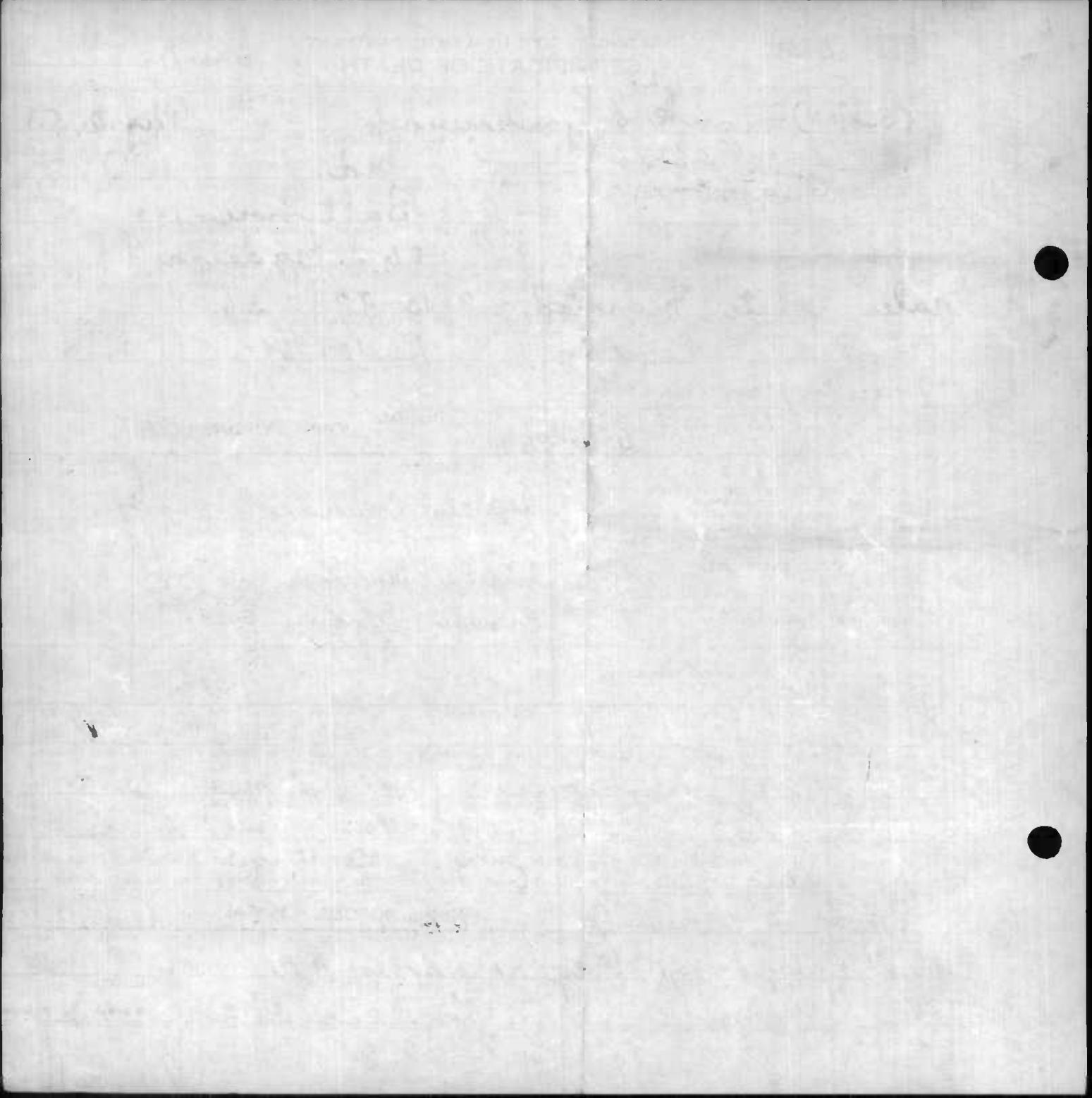
18. 581.1 and E903.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH (A) Aspiration Pneumonia DUE TO
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Subdural Hematoma DUE TO (C) Cirrhosis, Alcoholic

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
--	--

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office hldg., etc.) Home	21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 406 S. Madeira St.	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 8/1/53	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? fell and struck his head	
22. I hereby certify that I attended the deceased from July 19, 1953 to Aug 2, 1953 that I last saw the deceased alive on Aug 2, 1953 and that death occurred at 1:30 p.m., from the causes and on the date stated above.		23A. SIGNATURE Edward L. Alexander Jr. M.O.	
23B. ADDRESS JOHNS HOPKINS HOSPITAL		23C. DATE SIGNED August 12, 1953	

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE aug 6-1953	24C. NAME OF CEMETERY OR CREMATORY Holy Cross A.A. Co. A.A. Co.	24D. LOCATION (City, town, or county) Md
DATE RECEIVED BY LOCAL REGISTRAR 3 1953	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR Wm. S. Fialkowski	ADDRESS 2007 Eastern Ave

CERTIFICATION APPROVED BY  
Joseph J. Juchacz  
CHIEF OF ASST. MEDICAL EXAMINER.



K-652  
53 7022BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7022

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARY ELIZABETH KROMEKE

2. DATE  
OF DEATH

2 Aug. 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

3423 Mondawmin Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3423 Mondawmin Ave.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Single

8. DATE OF BIRTH

Mar. 3, 1873

9. AGE (in years  
last birthday)

80

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Seamstress

10B. KIND OF BUSINESS OR  
INDUSTRY

Self Employed

11. BIRTHPLACE (State or foreign country)

New York N. Y.

12. CITIZEN OF  
WHAT COUNTRY?  
USA

13. FATHER'S NAME

Werner Kromeke

14. MOTHER'S MAIDEN NAME

Mary Veronica Henning

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.  
No

17. INFORMANT

ADDRESS

Miss Veronica Kromeke

Above

18. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, assthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Acute Myocardial failure  
Uremia

8 hours

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Arteriosclerotic Degenerative  
Cardiovascular Disease.

Years

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE OATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

Senility

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 25, 1953 to 2 Aug, 1953, that I last saw the  
deceased alive on 2 Aug, 1953, and that death occurred at 11:30 A. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

8/5/53

Holy Redeemer Cem.

Baltimore Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 5 1953

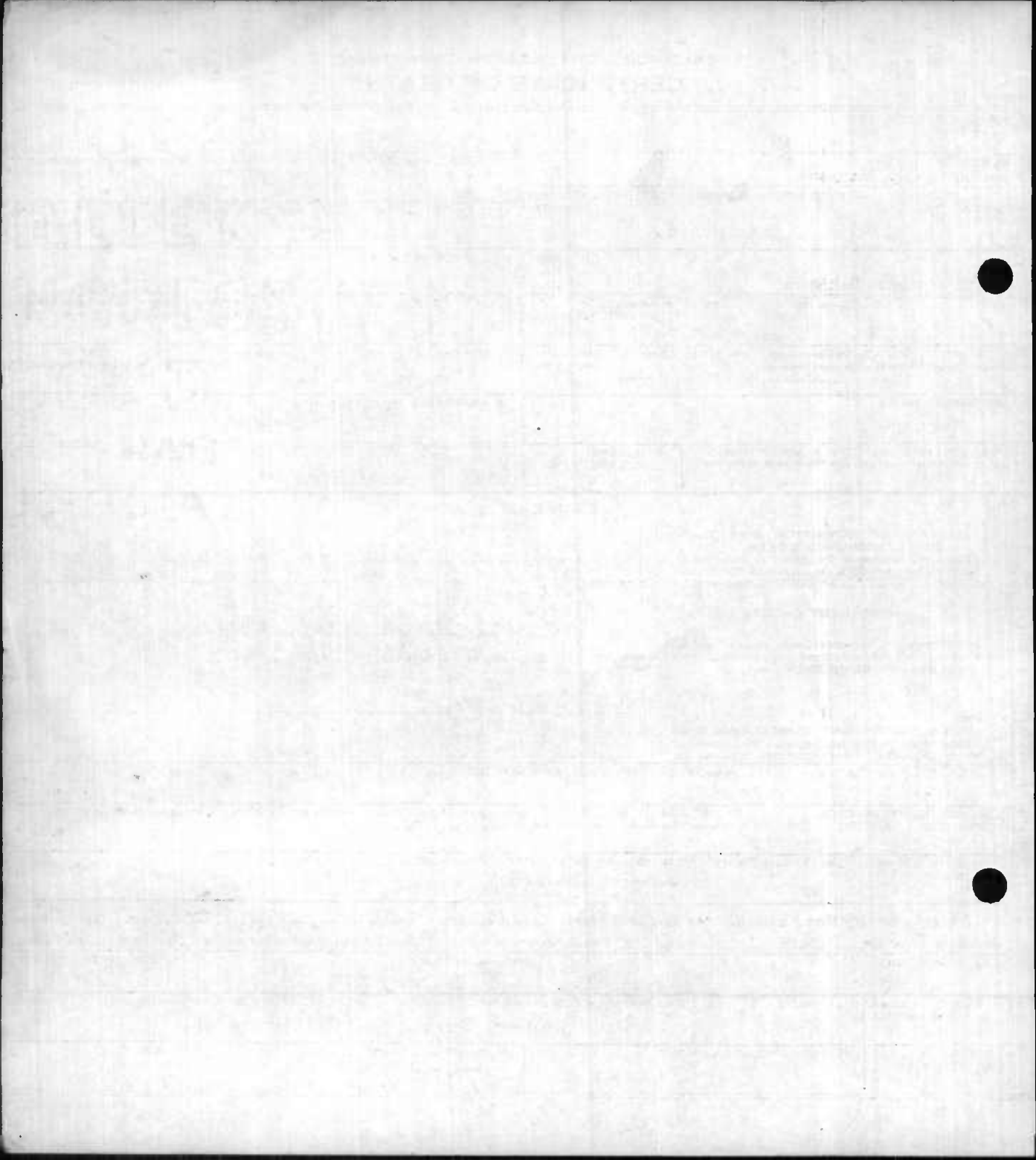
J. M. D. J. M. D.

5 West 29th St.

2 Aug '53

VS. 150

for Dr. Christopher J. Mendelis.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

53 7023  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

William R Hilley

2. DATE  
OF  
DEATH

AUG. 2, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (not in hospital or institution, give street address or location)

222 S. GILMORE ST.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTO

D. STREET ADDRESS (If rural, give location)

222 S. GILMORE ST.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M.

8. DATE OF BIRTH

MAR. 21, 1904

9. AGE (In years last birthday)

49

If Under 1 Year  
Months Days

If Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

FOUNDRY WORKER

10B. KIND OF BUSINESS OR INDUSTRY

METAL PROCESS

11. BIRTHPLACE (State or foreign country)

HONEYPATH S.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

L. BART HILLEY

14. MOTHER'S MAIDEN NAME

ESIE SMITH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

?

16. SOCIAL SECURITY NO.

218-08-1201

17. INFORMANT

ADDRESS

MRS. CAROL C. HILLEY 222 S. GILMORE ST.

18.

581.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

FATTY METAMORPHOSIS

DUE TO

OF LIVER

ANTECEDENT CAUSES

(B)

DUE TO

CHRONIC ALCOHOLISM

(C)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

PULMONARY EDEMA

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an AUTOPSY thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

Joseph A. Jachin

M.D.

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED  
8-2-53

24A. BURIAL, CREMATION, REMOVAL (Specify)

REMOVAL

24B. DATE

8-2-53

24C. NAME OF CEMETERY OR CREMATORY

ZION MEMORIAL

24D. LOCATION (City, town, or county)

CUMBERLAND MD

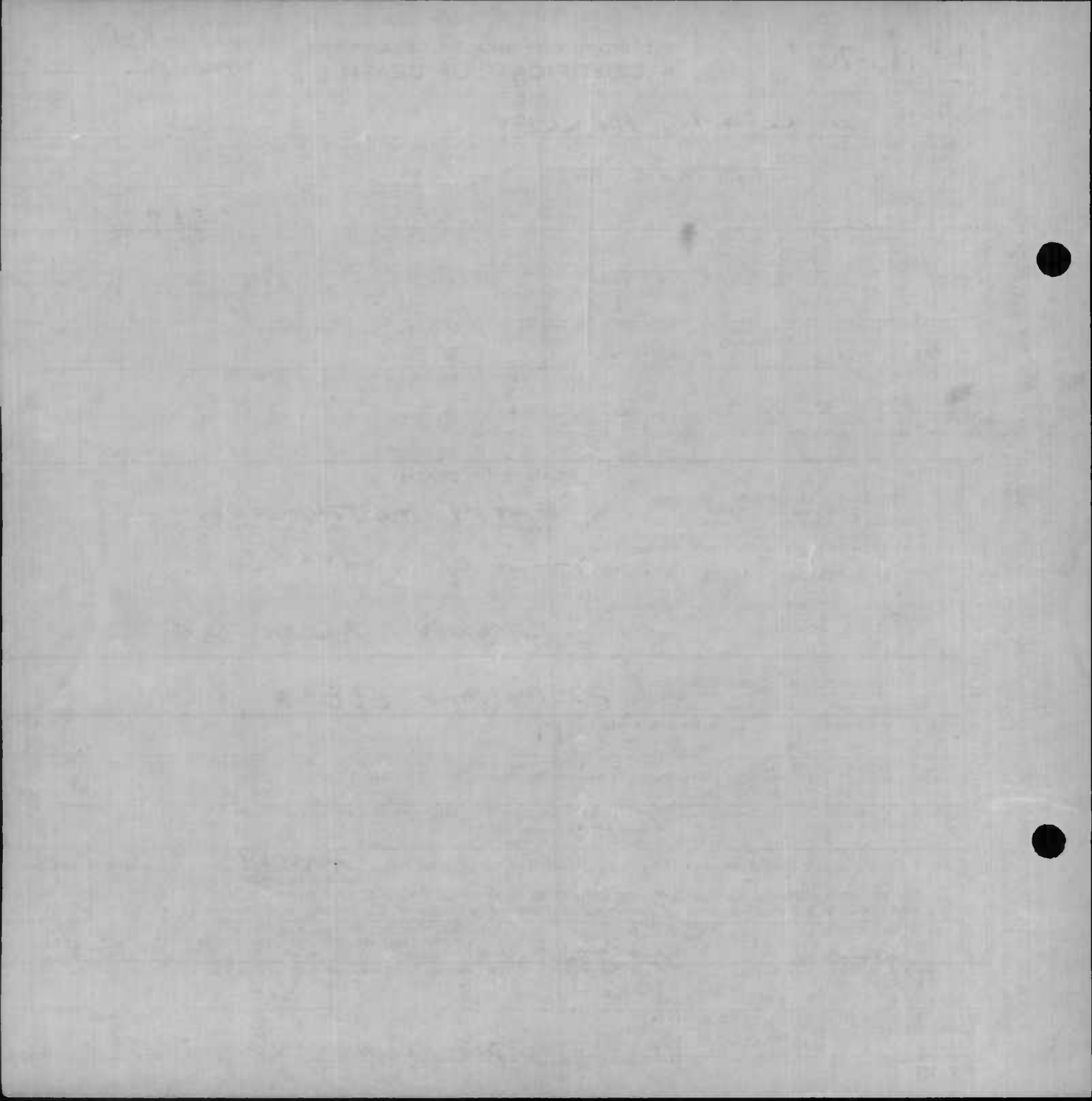
(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

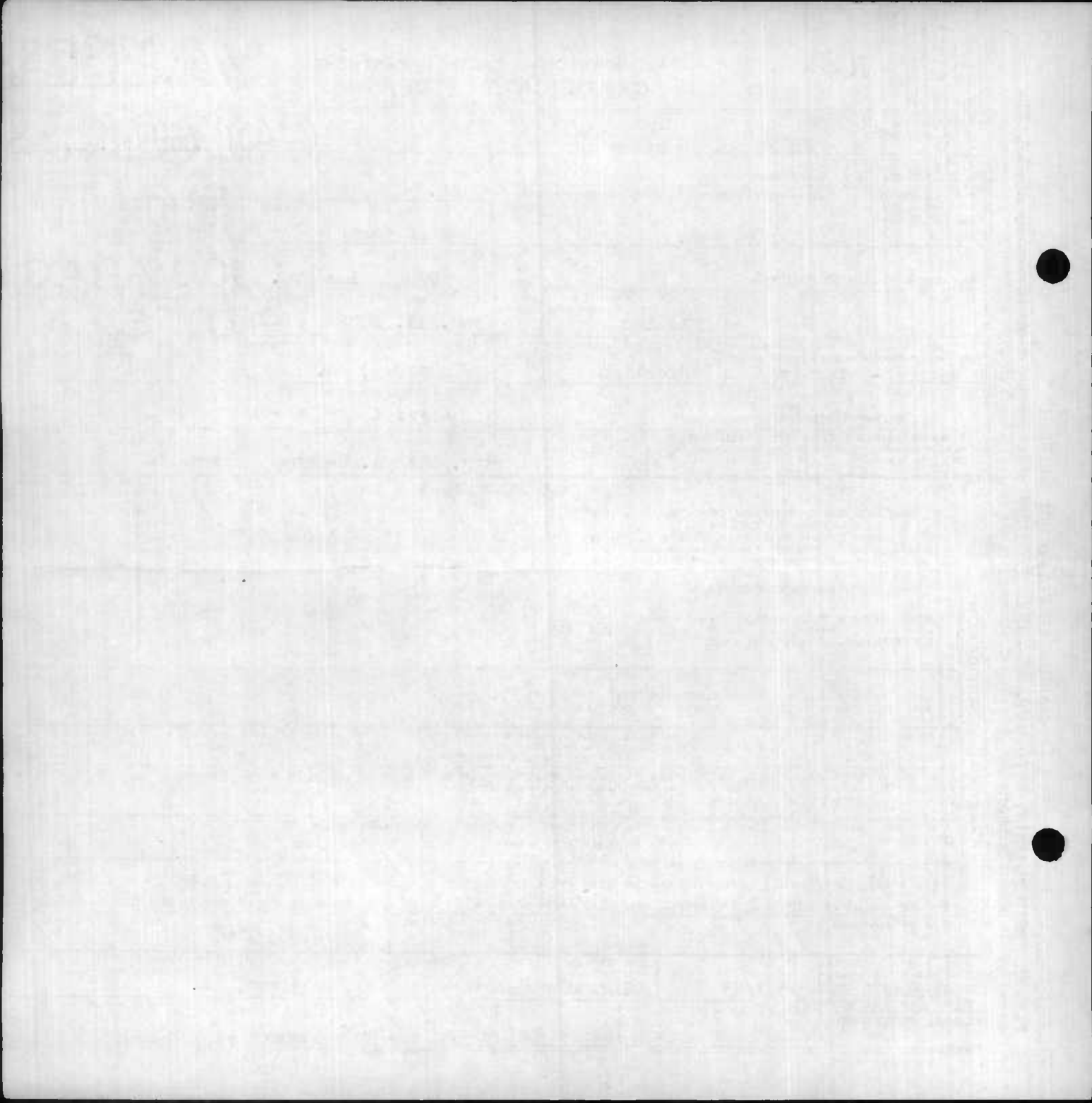
25. FUNERAL DIRECTOR

ADDRESS



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				53 7024		Registered No. _____	
BIRTH NO. _____							
1. NAME OF DECEASED (Type or Print) <b>JESSE HOIMES HAUGH SR</b>				2. DATE OF DEATH <b>XXIX Aug. 1, 1953</b>			
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>16-06</b>			
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>3020 Harlem Ave.</b>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>			
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____				D. STREET ADDRESS (If rural, give location) <b>3020 Harlem Ave.</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Dec. 11, 1875</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Year Months: _____ Days: _____	If Under 24 Hours Hours: _____ Min: _____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Detective</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Protection</b>		11. BIRTHPLACE (State or foreign country) <b>Taneytown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Jesse Haugh</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Ann Dubrow</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Mrs. Ruth A. Haugh</b>		ADDRESS <b>Above</b>	
18. <b>151X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Stomach</b> (A) _____ DUE TO _____				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES (B) _____ DUE TO _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) _____ DUE TO _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>June 19 1953</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cancer of Stomach</b>		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. _____		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>8/1/53</b>			
22. I hereby certify that I attended the deceased from <b>May</b> , 19 <b>53</b> , to <b>July 31</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>July 31</b> , 19 <b>53</b> , and that death occurred at <b>2 A</b> m., from the causes and on the date stated above.							
23A. SIGNATURE <b>[Signature]</b>		23B. ADDRESS <b>3924 Edmondson Ave.</b>		23C. DATE SIGNED <b>8/1/53</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/3/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 3 1953</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		25. FUNERAL DIRECTOR <b>[Signature]</b>		ADDRESS <b>[Address]</b>	



5-160  
53 7025BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7025  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CARRIE

SHAFFER

2. DATE  
OF  
DEATH

7/31/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

2602 Huron St

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Cal

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

Isaiah Chase

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

7/25/1883

9. AGE (In years  
last birthday)

70

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Gertrude Thomas

17. INFORMANT

ADDRESS

Maynard Brown 1503 W. Mulberry

18. 174X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

DUE TO

Carcinoma of Uterus

INTERVAL BETWEEN  
ONSET AND DEATH

4 yrs

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 10, 1950 to July 31, 1953 that I last saw the  
deceased alive on 7/20, 1953 and that death occurred at 4 P. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

8/3/53

Mt. Auburn

Baltimore Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Huntington Williams, Jr

Charles A. Rice 661 W. Barrett

63 VS 1503

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

2518 Edin  
a



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: write the causes of death clearly and legibly.

R-300  
53 7026

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7026  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*M. May Reed*

2. DATE  
OF  
DEATH

*8/1/53*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

*Md.*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

*Baltimore*

*20-05*

D. STREET ADDRESS (If rural, give location)

*25-77 Frederick Ave*

B. FULL NAME OF (If not in hospital or institution, give street address or location)

*25-77 Frederick Ave*

C. Length of stay in Baltimore

*77*

Yrs.  
Mos.  
Days

5. SEX

*Female*

6. COLOR OR RACE

*white*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*widowed*

8. DATE OF BIRTH

*2/26/1871*

9. AGE (In years last birthday)

*82*

If Under 1 Year  
Months Days

If Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*House work at home*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Westminister Md.*

12. CITIZEN OF WHAT COUNTRY?

*USA*

13. FATHER'S NAME

*Urias Mikesell*

14. MOTHER'S MAIDEN NAME

*Mary Schel*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*—*

16. SOCIAL SECURITY NO.

*—*

17. INFORMANT

*Mrs Sarah M. Fleming Frederick*

ADDRESS

18. *422.1*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Cardiac Failure*

DUE TO *Arterio-Sclerotic Cardio-Vascular Disease*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?  
YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *July 15, 1953*, to *Aug 1<sup>st</sup>, 1953*, that I last saw the deceased alive on *July 31, 1953*, and that death occurred at *2:26 a.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Alfred Scagnetti*

M. D.

23B. ADDRESS

*1729 W Lombard St*

23C. DATE SIGNED

*Aug 17 1953*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*8/4/53*

24C. NAME OF CEMETERY OR CREMATORY

*Louison Park Cem*

24D. LOCATION (City, town, or county)

*3801 Frederick Ave*

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

*John J. Cowan & Son*

ADDRESS

*1011*

RECEIVED OCTOBER 1961

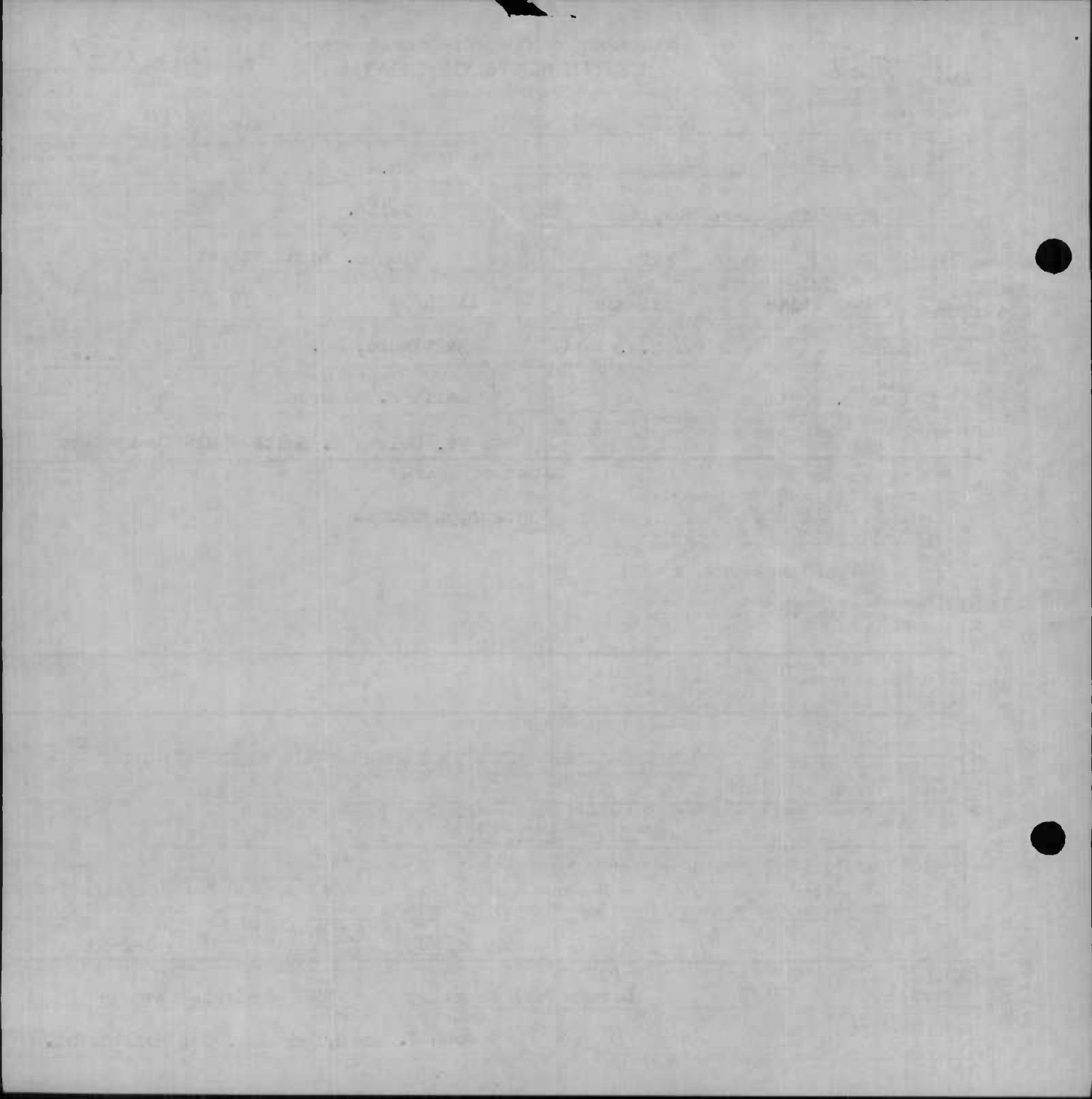
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

100-376  
BOND

CONFIDENTIAL  
VALLEY

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7027  
Registered No.

5-530 53 7027 BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		53 7027 Registered No.	
1. NAME OF DECEASED (Type or Print) <b>LOUIS LEON SMITH</b>			2. DATE OF DEATH <b>8/1/53</b>		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY		
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>Franklin Square Hospital</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto.</b>		
c. Length of stay in Baltimore <b>life</b>			d. STREET ADDRESS (If rural, give location) <b>104 S. Mount Street</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>11/14/33</b>		9. AGE (In years last birthday) <b>19</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>for E.A. Smith</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>Colvin A. Smith</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			14. MOTHER'S MAIDEN NAME <b>Lelia E. Anderson</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Mr. Colvin A. Smith</b> ADDRESS <b>819 Cooks Lane</b>		
18. <b>491X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Bronchopneumonia</b> DUE TO ANTECEDENT CAUSES (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <b>AUTOPSY</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .					
23a. SIGNATURE <i>Joseph G. Jashinsky</i>		23b. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23c. DATE SIGNED <b>8-2-53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>8/5/53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>3801 Frederick Avenue</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>8-3-53</b>	REGISTRAR'S SIGNATURE <i>Montgomery E. ...</i>	25. FUNERAL DIRECTOR <b>John J. Cowan and Son. 901 Hollins St.</b>			



G-264

53 7028

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7028

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Martin John Casserly

2. DATE  
OF  
DEATH

8/1/1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore CityB. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

So. Baltimore Gen. Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE Maryland

B. COUNTY

before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore City

23-02

D. STREET ADDRESS (If rural, give location)

1531 S. Charles Street

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Printer

10B. KIND OF BUSINESS OR INDUSTRY

Commercial Printing

13. FATHER'S NAME

John B. Casserly

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Mary F. Rudolph

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mary R. Casserly 1531 S. Charles St.

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Posterior coronary artero occlusion days  
(C) Generalized arterio sclerosis years

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Bilateral pneumonitis

Hours

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK

NOT WHILE AT WORK

22. I hereby certify that I attended the deceased from 7-29, 1953, to 8-1-1953, that I last saw the deceased alive on 8-1-1953, and that death occurred at 2 p. m., from the causes and on the date stated above.

22A. SIGNATURE

22B. ADDRESS

22C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

8/5/1953

Cathedral

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

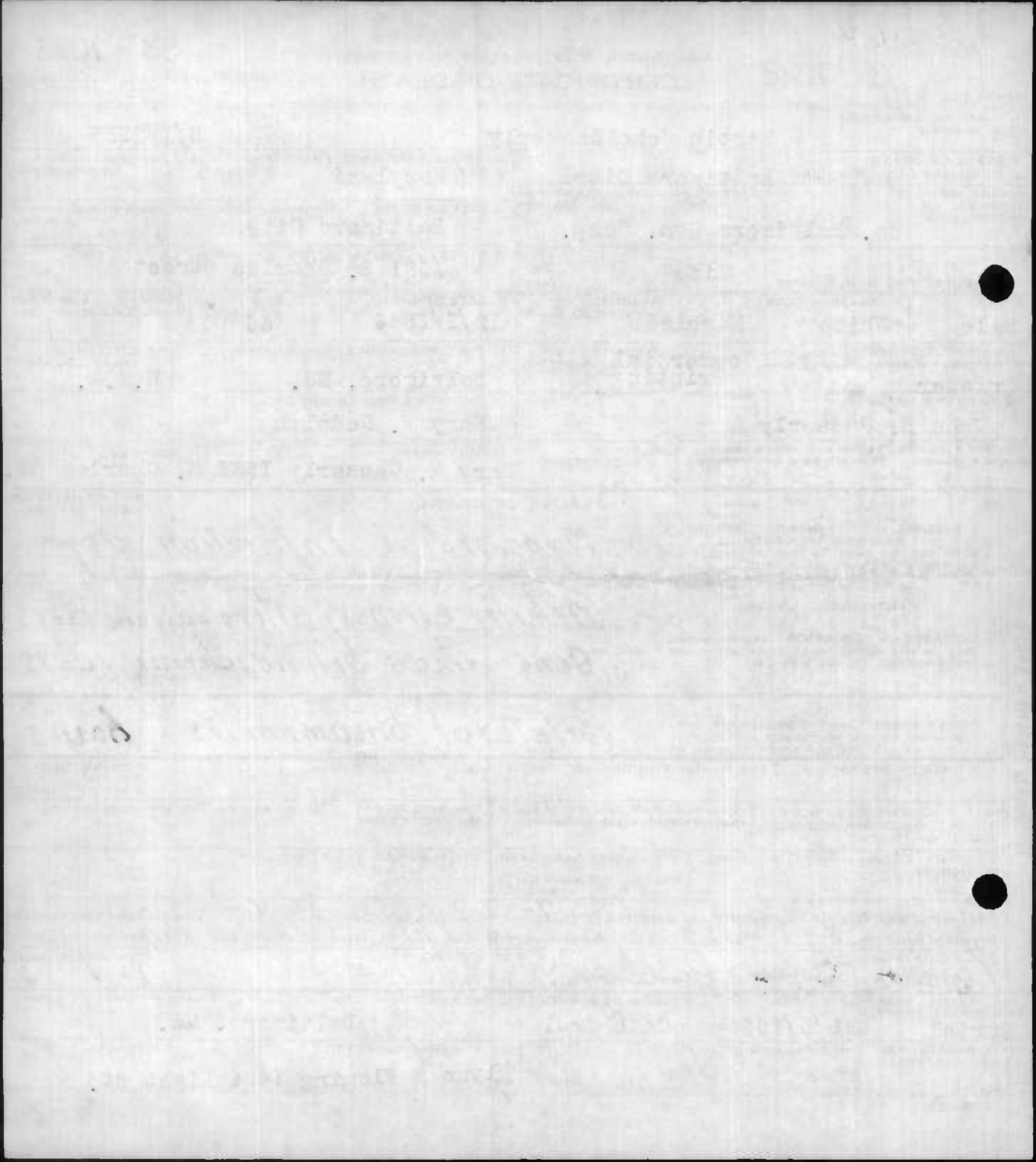
VS 150

Huntington Williams, M.D.

Flynn &amp; Fleming 1426 Light St.

51244

MEDICAL CERTIFICATION





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **53 7029**

**BIRTH NO.** **53 7029**

**1. NAME OF DECEASED** (Type or Print) *Carl R. Apxen*

**2. DATE OF DEATH** *8/1/53*

**3. PLACE OF DEATH:**  
A. *Baltimore City, Maryland*

**4. USUAL RESIDENCE** (Where deceased lived, if institution; residence before admission)  
A. STATE *Baltimore* B. COUNTY *Calvert*

**5. FULL NAME OF** (If not in hospital or institution, give street address or location)  
*Mayland, Grand*

**6. CITY OR TOWN** (If outside corporate limits, write RURAL and give township)  
*Baltimore 14-01*

**7. STREET ADDRESS** (If rural, give location)  
*1519 Linden Lane*

**8. Length of stay in Baltimore**  
Yrs. Mos. Days

**9. SEX** *M* **10. COLOR OR RACE** *W*

**11. SINGLE, MARRIED, WIDOWED, DIVORCED** (Specify)  
*Divorced*

**12. DATE OF BIRTH** *11/26/1898*

**13. AGE** (In years last birthday) *55*

**14. Under 1 Year** Months: Days: **15. Under 24 Hours** Hours: Min.

**16. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired)

**17. KIND OF BUSINESS OR INDUSTRY**

**18. BIRTHPLACE** (State or foreign country) *W. Va*

**19. CITIZEN OF** *U.S.*

**20. FATHER'S NAME** *Elmer Apxen*

**21. MOTHER'S MAIDEN NAME** *Kathie Garner*

**22. WAS DECEASED EVER IN U. S. ARMED FORCES?** (If yes, give war or dates of service) *Yes*

**23. SOCIAL SECURITY NO.**

**24. INFORMANT** **25. ADDRESS**

**18. 163X**

**CAUSE OF DEATH**

**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
(A) *Coronary Thrombosis*  
DUE TO

**ANTECEDENT CAUSES**  
(B) *None*  
DUE TO

(C) *None*

**II**  
**OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.**

**19A. DATE OF OPERATION** *8/1/53* **19B. MAJOR FINDINGS OF OPERATION**

**20. AUTOPSY?** YES ☐ NO ☐

**21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH** ☐

**21B. PLACE OF INJURY** (e. g., in or about home, farm, factory, street, office bldg., etc.)

**21C. WHERE DID INJURY OCCUR?** (If in Baltimore City, give exact location)

**21D. TIME** (Month) (Day) (Year) (Hour) OF INJURY

**21E. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☒

**21F. HOW DID INJURY OCCUR?**

**22. I hereby certify** that I attended the deceased from *8/1/53* to *8/1/53*, that I last saw the deceased alive on *8/1/53*, and that death occurred at *5:30 PM*, from the causes and on the date stated above.

**23A. SIGNATURE** *D. T. O'Leary* **23B. ADDRESS** *1017 North Avenue, Baltimore, Md.* **23C. DATE SIGNED** *8/1/53*

**24A. BURIAL, CREMATION, REMOVAL** (Specify) *Buried* **24B. DATE** *8/6/53* **24C. NAME OF CEMETERY OR CREMATORY** *Masonic Cemetery* **24D. LOCATION** (City, town, or county) *Pennsboro, Ritchie Co. W. Va*

**25. FUNERAL DIRECTOR** **26. ADDRESS**

**DATE RECEIVED BY LOCAL REGISTRAR** *Huntington Williams, M.D.* **27. FUNERAL DIRECTOR** *W. H. Newbold* **28. ADDRESS** *3202 W. North Ave.*

AUG 3 1953

VS 150

Know all men by these presents, that

the undersigned, for and in consideration of the sum of

Five hundred and no/100 Dollars, to him in hand paid by

the said [Name], the receipt of which is hereby acknowledged,

have granted, sold and conveyed, and by these presents do

grant, sell and convey unto the said [Name], his heirs and assigns

forever, all that certain [Description of Land]

situated in the County of Dallas, State of Texas, to have and

enjoy unto the said [Name], his heirs and assigns forever,

all the rights and appurtenances in anywise in anywise

in anywise in anywise in anywise in anywise in anywise

in anywise in anywise in anywise in anywise in anywise

in anywise in anywise in anywise in anywise in anywise

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE L. WRIGHT JR.

2. DATE  
OF  
DEATH

8-2-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Md

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

University Hosp

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Balto

D. STREET ADDRESS (If rural, give location)

711 N. Fremont

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

7-25-77

9. AGE (In years  
last birthday)

78

If Under 1 Year If Under 24 Hours  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

sext on

10B. KIND OF BUSINESS OR  
INDUSTRY

Church

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Wright

14. MOTHER'S MAIDEN NAME

Henrietta Bell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Geo. L. Wright Jr - 711 Fremont

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

CARDIAC DECOMPENSATION

DUE TO

ANTECEDENT CAUSES

(B)

ARTERIOSCLEROTIC CARDIO-

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

VASCULAR DISEASE

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

ASCITES

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
M. WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an inspection & inquiry thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23. SIGNATURE

Joseph A. Jarhimczyk

M.D.

23B. CHIEF MEDICAL EXAMINER ☐  
MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED

8-2-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

B.

24B. DATE

8-5-53

24C. NAME OF CEMETERY OR CREMATORY

Mt. Zion

24D. LOCATION (City, town, or county)

Balto.

(State)

Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

ADDRESS

Samuel W. Sullivan Jr

1011 N. Arlington Ave

V S 151

3. 1920

RECEIVED THE BOARD OF DEATH

THE BOARD OF DEATH

THE BOARD OF DEATH

THE BOARD OF DEATH

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THE BOARD OF DEATH

THE BOARD OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

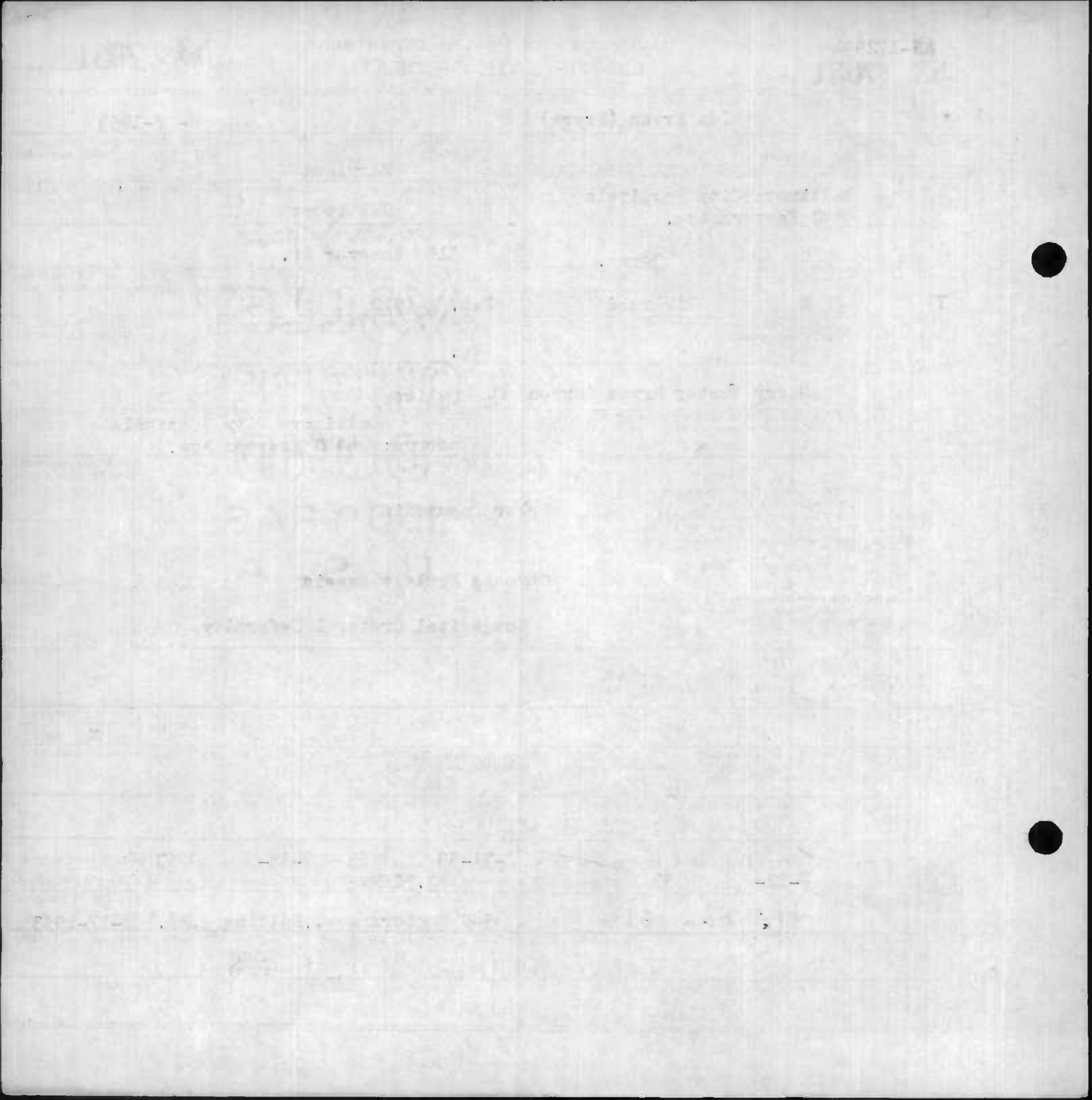
13-650  
AB-172934  
53 7031

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7031

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Ida Bryan (Bryon)		8-12-1953	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
		A. STATE Maryland	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE Baltimore City Hospitals 4940 Eastern Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 22-01	
c. Length of stay in Baltimore 34yrs.		D. STREET ADDRESS (If rural, give location) 518 Hanover St.	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Feb. 2-1912
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 41
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harry Paster Bryan (Bryon)		14. MOTHER'S MAIDEN NAME Alice	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Baltimore City Hospitals Records: 4940 Eastern Ave.			

18. 600.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) Lobar Pneumonia		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) Chronic Pyelonephrosis		
(C) Congenital Ureteral Deformity		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 7-31-53, 1953 to 8-12-1953, that I last saw the deceased alive on 8-12-1953, and that death occurred at 3.30PM., from the causes and on the date stated above.		
23A. SIGNATURE H. J. Williams	23B. ADDRESS M. D. 4940 Eastern Ave., Baltimore, Md.	23C. DATE SIGNED 8-17-1953
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY
		24D. LOCATION (City, town, or county) (State)
DATE RECEIVED BY LOCAL REGISTRAR AUG 28 1953	REGISTRAR'S SIGNATURE Huntington Williams	25. FUNERAL DIRECTOR Huntington Williams





S-400  
53 7032BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7032  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JAMES SCHOLL</b>		2. DATE OF DEATH <b>8/1/53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>City Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore Maryland</b>			
c. Length of stay in Baltimore <b>41 years</b>		D. STREET ADDRESS (If rural, give location) <b>3536 Clifftmont Ave 26-03</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 3, 1912</b>	9. AGE (In years last birthday) <b>41</b>	If Under 1 Year Months Days If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sargent</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Police Dept.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
13. FATHER'S NAME <b>Mark R. Scholl</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>Catherine Stilely</b>	
17. INFORMANT <b>Mrs. Margaret Scholl</b>		ADDRESS <b>3536 Clifftmont</b>			
18. <b>E981X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE PERITONITIS</b> DUE TO <b>PERFORATION OF SIGMOID</b> <b>BUNSHOT WOUNDS OF ABDOMEN.</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO		(B) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II UREMIA</b>		(C) DUE TO			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Tavern</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>1800 Block Browning Highway</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>7/20/53</b>		21E. INJURY OCCURRED WHILE AT <input checked="" type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fire arms</b>	
22. I certify that I took charge of the remains described above, held an <b>AUTOPSY</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>Joseph A. Jachimczyk</b>		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <b>8-2-53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/5/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery Balto. Md.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25. FUNERAL DIRECTOR <b>L. J. Buck</b>		ADDRESS <b>3305 Harford Road-14</b>	

UNITED STATES OF AMERICA

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

STATE DEPARTMENT  
WASHINGTON, D. C.

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

M-620

53 7033

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7033

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Dr. Mary Elizabeth Morse

2. DATE  
OF  
DEATH

8-1-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

Balto.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

O. STREET ADDRESS (If rural, give location)

Baltimore CATONSVILLE  
Bonnie View nursing home  
Remond Ave. Balto. Md.B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

The Hospital For Women of Md

C. Length of stay in Baltimore

70

5. SEX

Fe

6. COLOR OR RACE

Wt

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

2-16-78

9. AGE (In years

75

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Dr.

10B. KIND OF BUSINESS OR INDUSTRY

Author of Med. Texts

11. BIRTHPLACE (State or foreign country)

Montpelier Vermont

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Harrison Morse

14. MOTHER'S MAIDEN NAME

Cardine Brooks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Charles E. Quandt Balto. Life Bldg

18. 420.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary Thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Arteriosclerotic Heart Disease.

(C)

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

M.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 28, 1953 to Aug 1, 1953, that I last saw the deceased alive on Aug 1, 1953, and that death occurred at 8:53 a.m., from the causes and on the date stated above.

23A. SIGNATURE

A. Regan

M. O.

23B. ADDRESS

Hosp. for Women of Md.

23C. DATE SIGNED

8/1/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 11, 1953

24C. NAME OF CEMETERY OR CREMATORY

Wildwood Cemetery

24D. LOCATION (City, town, or county)

Amhurst, Massachusetts

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

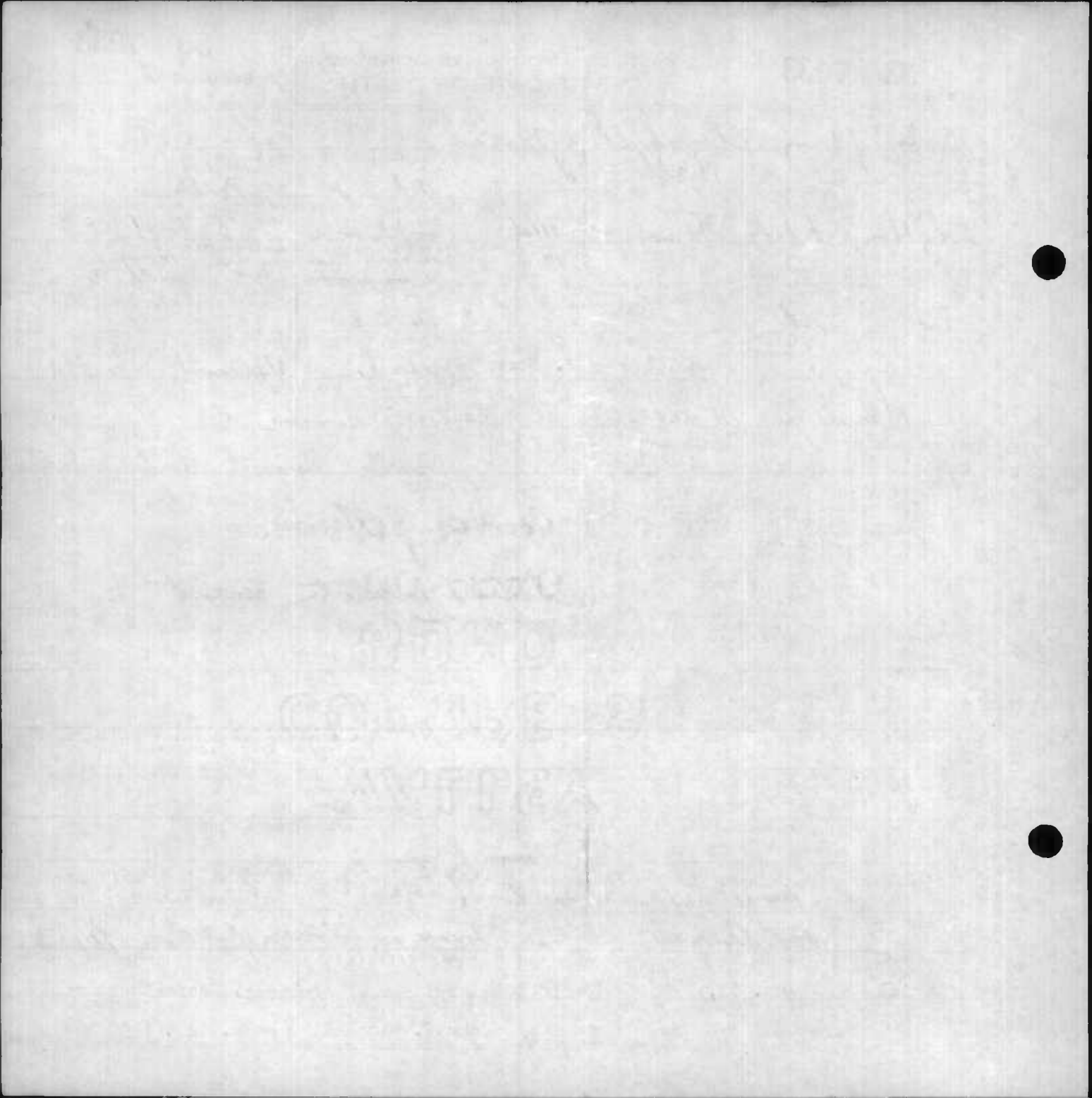
Huntington Williams, MD

25. FUNERAL DIRECTOR

John O. Mitchell &amp; Sons, Inc. 1900 Eutaw

ADDRESS

Place



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-250

53 7034

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7034

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ANN SUSSON

2. DATE OF DEATH August 2, 1953

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-02

7. STREET ADDRESS (If rural, give location) 234 N. Port Street

8. Length of stay in Baltimore Yrs. Mos. Days

9. SEX Female 10. COLOR OR RACE White 11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single

12. DATE OF BIRTH May 12-1945 13. AGE (In years last birthday) 8 14. Under 1 Year Months: Days: 15. Under 24 Hours Hours: Min.

16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Girl 17. KIND OF BUSINESS OR INDUSTRY

18. BIRTHPLACE (State or foreign country) Balto. Md. 19. CITIZEN OF WHAT COUNTRY?

20. FATHER'S NAME Charles H. Sussan 21. MOTHER'S MAIDEN NAME Mildred A. Mohley

22. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 23. SOCIAL SECURITY NO. 24. INFORMANT Mildred A. Sussan 25. ADDRESS 234 N. Port St.

18. E929.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Drowning (A) DUE TO ANTECEDENT CAUSES (B) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIB-UTING ☐ CAUSE OF DEATH. 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Water 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Bowley's Quarters 5200

21D. TIME (Month) (Day) (Year) (Hour) August 2, 1953 3:10 P. M. 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21F. HOW DID INJURY OCCUR? Drowned while trying to swim

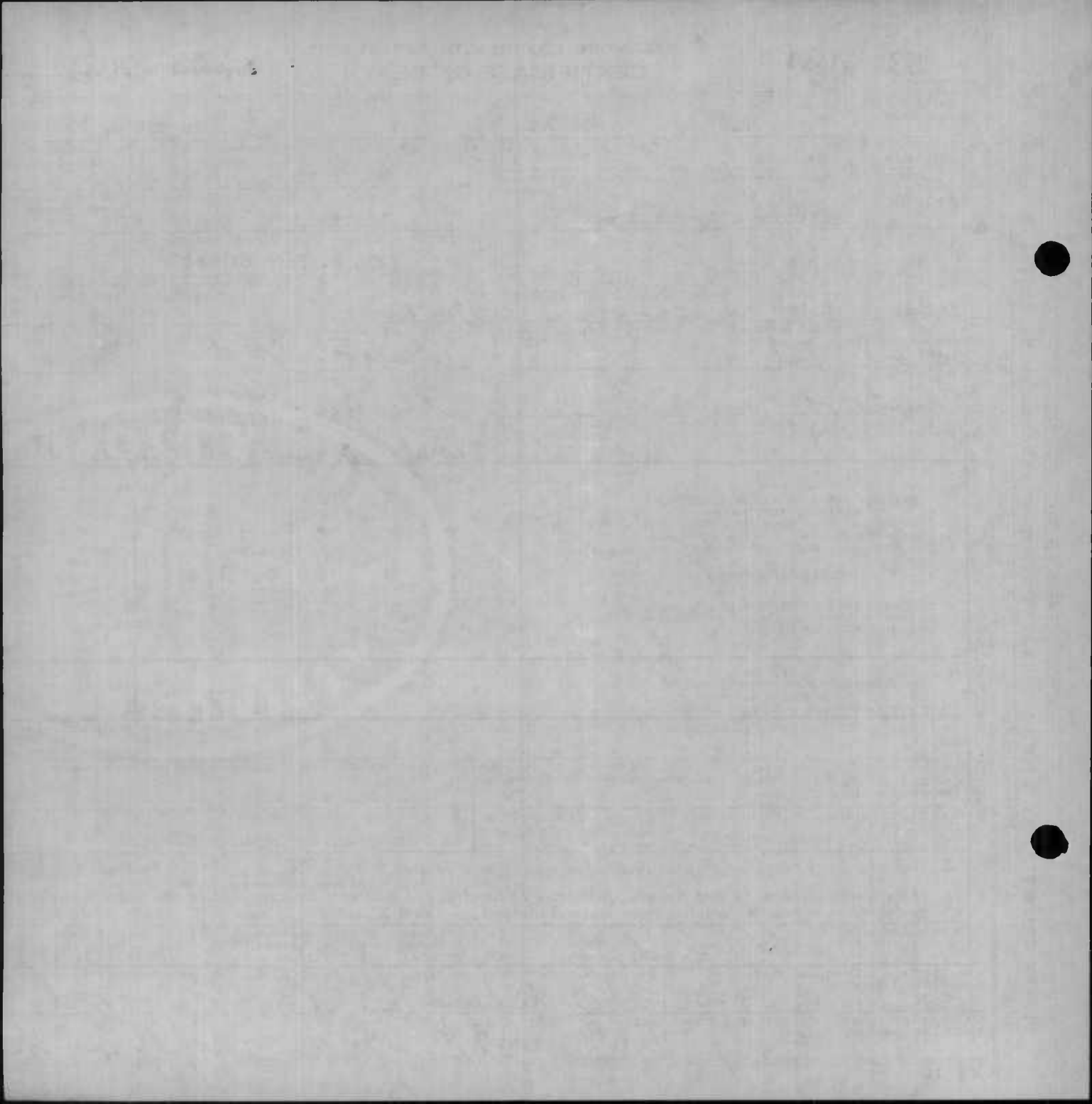
22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE R. J. Fisher 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ 23C. DATE SIGNED August 3, 1953

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE Aug. 5-53 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem 24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR John R. Miller 26. ADDRESS 2334 Jefferson St.

V.S. 151 N 990x





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BOWLES - BOWNLES  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

53 7035

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Sharon Bowles

2. DATE  
OF  
DEATH

August 3, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Clement

D. STREET ADDRESS (If rural, give location)

6800

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Female

White

Single

8. DATE OF BIRTH

7-19-52

9. AGE (In years last birthday)

1

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Bowles

14. MOTHER'S MAIDEN NAME

SUSAN ALBERTA ELLIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. E922.0 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

3 Aug 53.

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Respiratory obstruction

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

Clement, Md. (St. Mary's)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

Feb. 1953

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Child swallowed a safety pin.

22. I hereby certify that I attended the deceased from 7-31, 1953, to 8-3, 1953, that I last saw the deceased alive on 8-3, 1953, and that death occurred at 6:19 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Sharon Bowles, M.D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/5/53

24C. NAME OF CEMETERY OR CREMATORY

Clement

24D. LOCATION (City, town, or county)

Morganza

(State)

Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

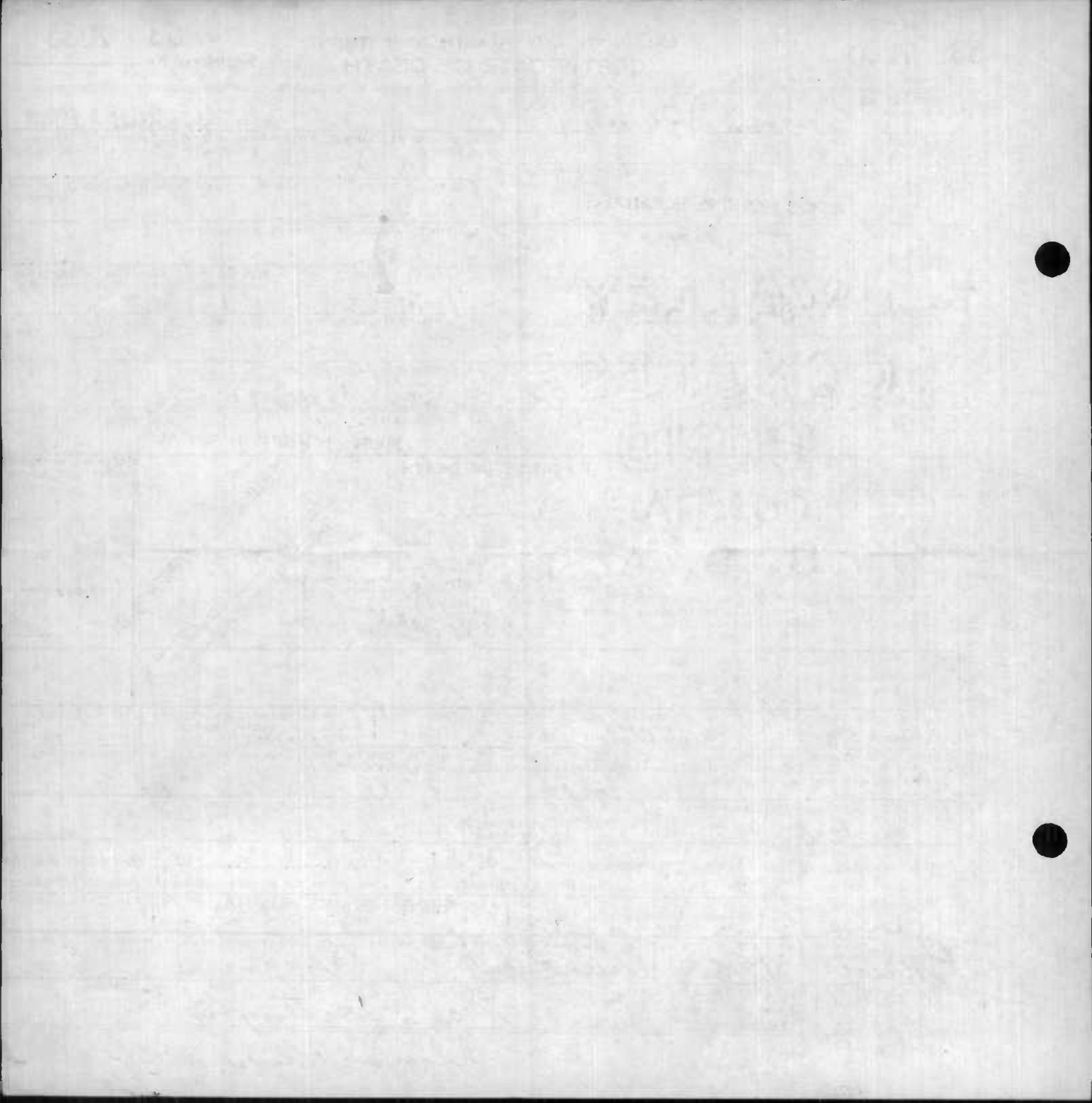
Jas. C. Mattingly

ADDRESS

Hoardtown, Md

VS 150

N 935.0



A-450

53 7036

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7036

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Thomas Blundell Allen</b>		2. DATE OF DEATH <b>August 3, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Lutheran Hospital</b>			
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Lutheran Hospital</b> <b>Baltimore, Maryland</b>			
C. Length of stay in Baltimore <b>eight</b> <sup>Yrs.</sup> <sup>Mos.</sup> <sup>Days</sup>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>July 12, 1892</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corporation</b> <b>Cumberland, Md.</b>	
13. FATHER'S NAME <b>Thomas Allen</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Lake Marker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <b>information given by Mrs. Annie M. Allen, wife of deceased</b>		ADDRESS <b>310 Waverly Terrace</b>	

18. **443X**  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

## CAUSE OF DEATH

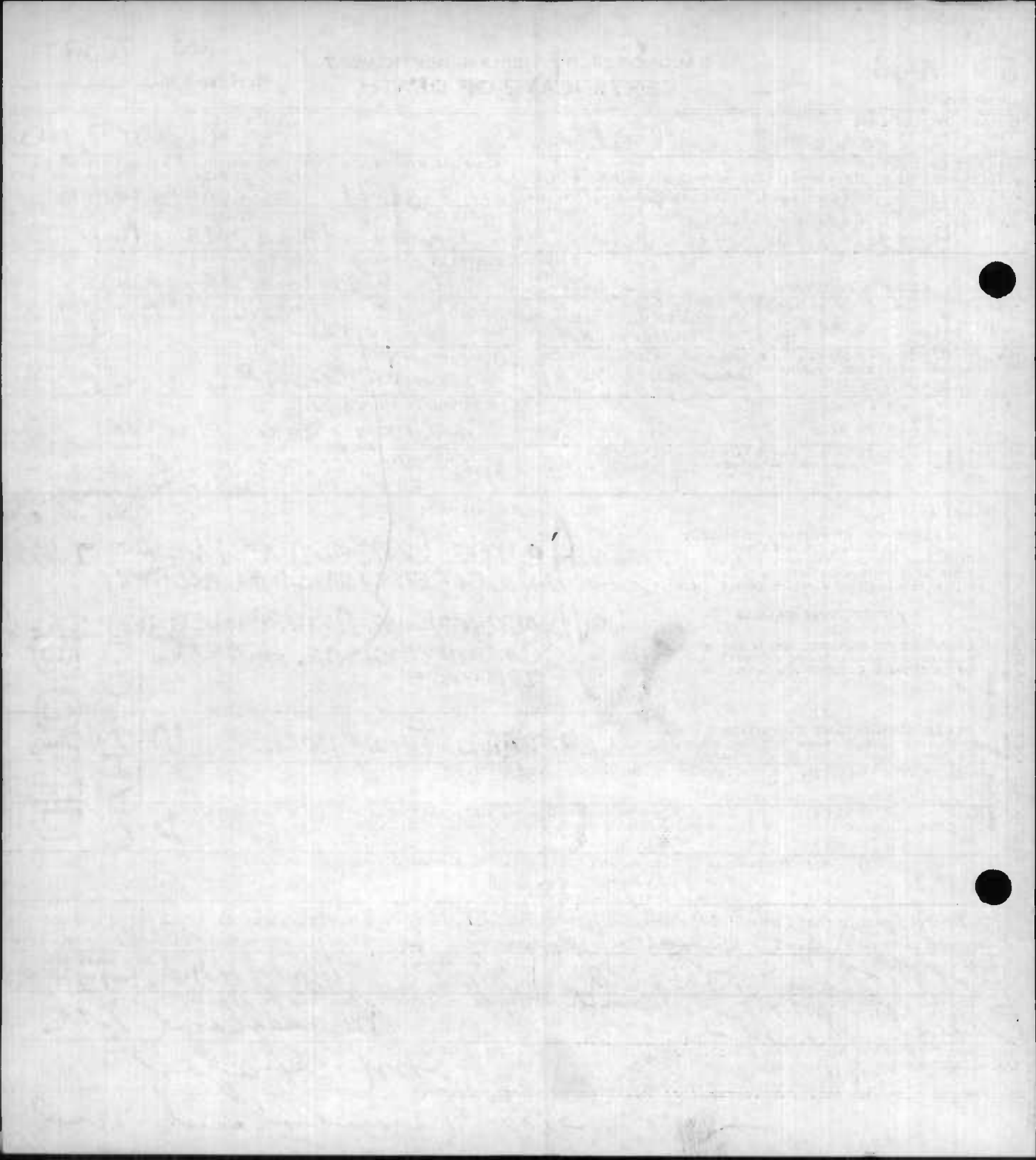
(A) **ACUTE CONGESTIVE FAILURE 2 DAYS AND CEREBROVASCULAR ACCIDENT**  
DUE TO

(B) **HYPERTENSIVE ARTERIOSCLEROTIC 2 YEARS PLUS CARDIOVASCULAR HEART DISEASE**  
DUE TO

(C) **CEREBRAL THROMBOSIS**  
DUE TO

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION <b>✓</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>August 1, 1953</b> to <b>August 3, 1953</b> , that I last saw the deceased alive on <b>August 3, 1953</b> , and that death occurred at <b>2:35 a.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>William D. Rosen</b>		23B. ADDRESS <b>Lutheran Hospital of Md.</b>		23C. DATE SIGNED <b>August 8, 1953</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>8/6/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Cumberland Md.</b>	
24D. LOCATION (City, town, or county) <b>Cumberland Md.</b>		25. FUNERAL DIRECTOR <b>John Haper</b>		ADDRESS <b>7704 N. Cumberland Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 4 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington</b>			



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 53 7037

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES

MC TEER

2. DATE  
OF DEATH August 3, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. City

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Provident Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3309 W. Paton Avenue

c. Length of stay in Baltimore

15 Yrs.Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Jan. 11, 1915

9. AGE (In years last birthday)

38If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

Trucking

11. BIRTHPLACE (State or foreign country)

Richmond Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ruffus Mc Teer

14. MOTHER'S MAIDEN NAME

Ella Wes Holloway

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Rula M. Teer18. 443XCAUSE OF DEATH 3309 Paton Av.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)(A) Hypertensive and arterioscleroticcardiovascular disease

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) .....

DUE TO

(C) .....

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William H. Wilson23B. CHIEF MEDICAL EXAMINER ☒M.D. ASSISTANT MEDICAL EXAMINER ☐MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

August 3, 1953

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/6/1953

24C. NAME OF CEMETERY OR CREMATORY

National Cem.

24D. LOCATION (City, town, or county)

Richmond Va.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 4 1953

REGISTRAR'S SIGNATURE

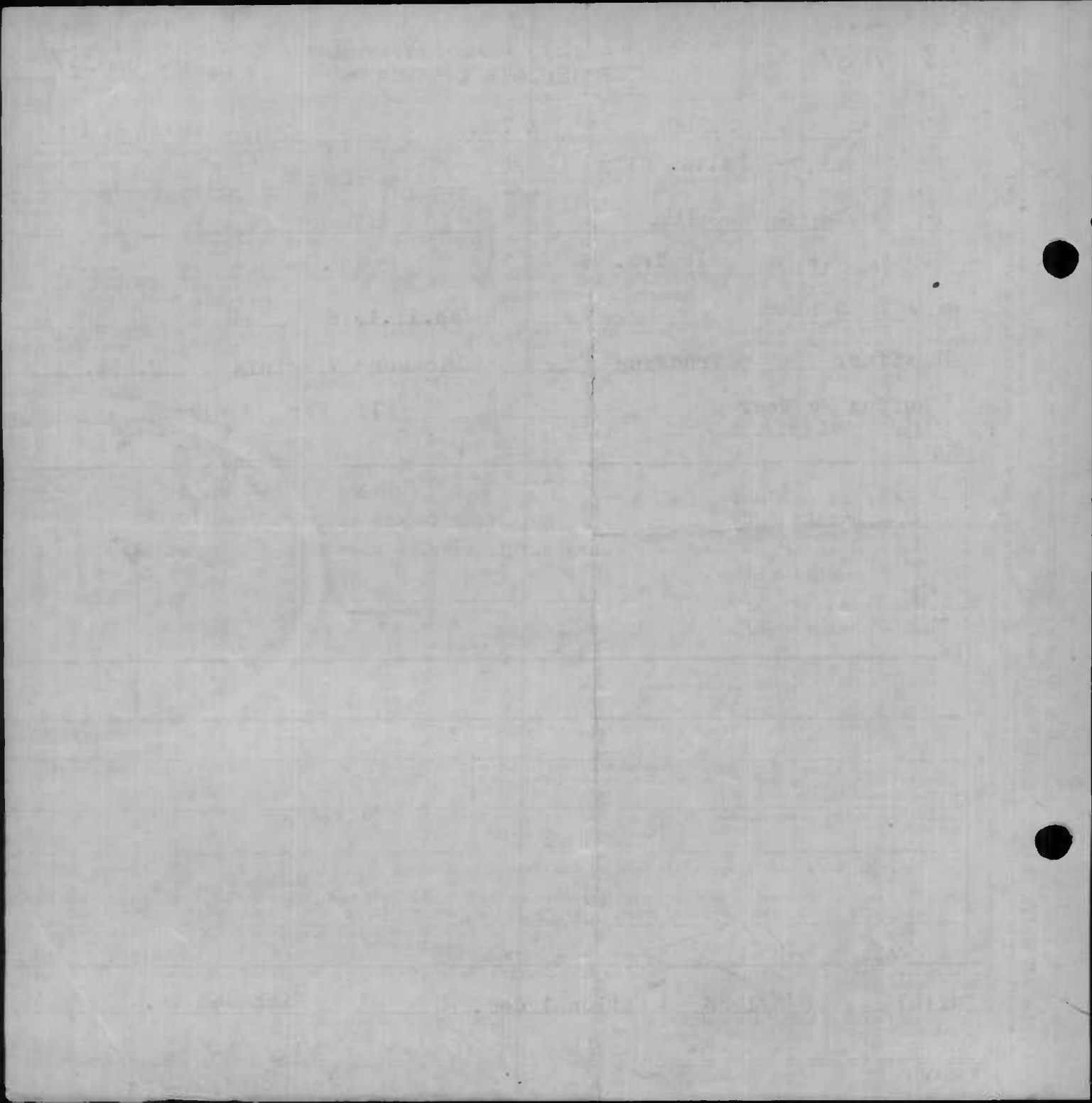
Huntington Wilson

25. FUNERAL DIRECTOR

Thos. J. Wilson

ADDRESS

68352 1000 Brantley Av





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

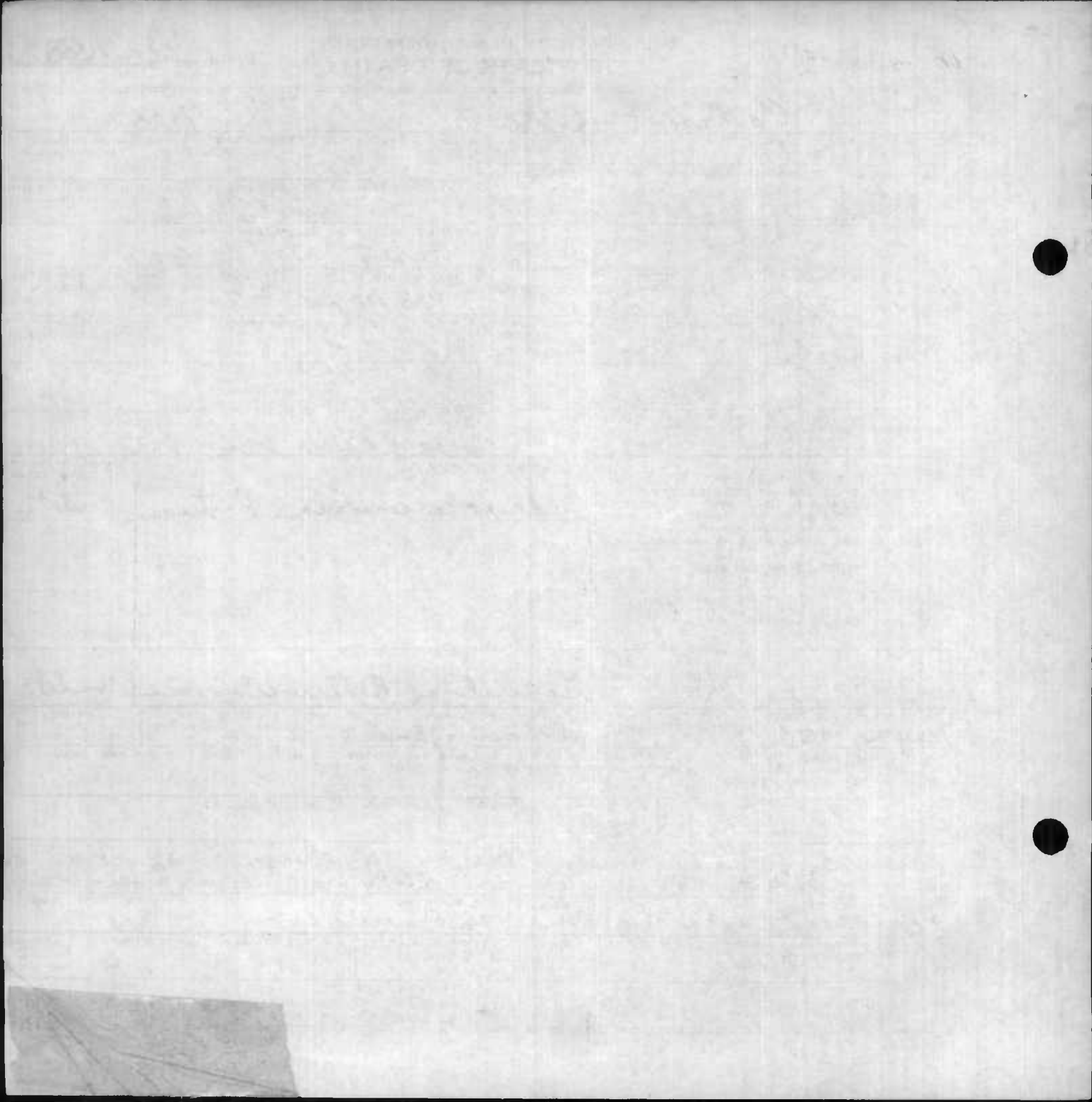
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. **53 7038**

**R-235**  
**53 7038**  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Catherine R. Riston</b>		2. DATE OF DEATH <b>8/1/53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>3609 Belle Ave</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto 15-11</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>3609 Belle Ave</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>10/5/1874</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	9. AGE (In years last birthday) <b>78</b>
11. BIRTHPLACE (State or foreign country) <b>N. J.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Gottlieb Gosman</b>		14. MOTHER'S MAIDEN NAME <b>(Unknown) Camp</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Samuel Riston</b>		ADDRESS <b>3609 Belle Ave.</b>	

18. <b>154x</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Adenocarcinoma Rectum</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Generalized Arteriosclerosis</b> DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH <b>Adenocarcinoma Rectum</b> DUE TO <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>	
19A. DATE OF OPERATION <b>May 26, 1953</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>obstruction of bowels</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>May 26, 1953</b> to <b>Aug. 1, 1953</b> , that I last saw the deceased alive on <b>July 31, 1953</b> , and that death occurred at <b>4:50 P.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>d. Bradley Laugherty MD.</b>		23B. ADDRESS <b>1263 Francis Ave.</b>		23C. DATE SIGNED <b>8-3-53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/4/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25. FUNERAL DIRECTOR <b>Huntington</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>Aug 4 1953</b>		ADDRESS <b>1217 St. Paul St.</b>			



5-563

53 7039

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7039

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Frederick Robert Smart

2. DATE  
OF  
DEATH

8-2-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Union Memorial Hosp.

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

RET. VICE-PRES. J.C. BUDNICK CO - SUPPLIES

10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

Frederick Smart

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.  
173-03-92404. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Md.

Balto.

C. CITY OR TOWN

Balto.

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Tudor Arms Apts.

8. DATE OF BIRTH

Nov 13, 1872

9. AGE (In years  
last birthday)

80

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF  
WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Emma Seaman

17. INFORMANT

Mrs Fred. Smart

ADDRESS

Same

18. 550.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Myocardial Infarction

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Generalize &amp; Coronary Arteriosclerosis

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Perforated Appendix

19A. DATE OF OPERATION

8-1-53

19B. MAJOR FINDINGS OF OPERATION

Perforated appendix

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-1-1953 to 8-2-1953, that I last saw the  
deceased alive on 8-2-1953 and that death occurred at 7:33 Pm., from the causes and on the date stated above.

23A. SIGNATURE

Louise Schrauber

M. D.

23B. ADDRESS

Union Memorial Hosp

23C. DATE SIGNED

8-2-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

8/4/53

24C. NAME OF CEMETERY OR CREMATORY

DEWID RIDGE CEMETERY

24D. LOCATION (City, town, or county)

PIKESVILLE

(State)

MARYLAND

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Thom. Cook, Inc.

ADDRESS

1217 St. Paul St.

DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS

STATE OF NEW YORK  
COUNTY OF ALBANY  
DEATH

DATE

TIME

PLACE OF BIRTH  
PLACE OF DEATH  
PLACE OF INTERMENT

SEX  
AGE

CAUSE OF DEATH

DIAGNOSIS

DATE OF DEATH

SIGNATURE

C-260 Twin

53 7040

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7040

BIRTH NO. 53-18253

1. NAME OF DECEASED  
(Type or Print)

BABY BOY COGAR

2. DATE  
OF  
DEATH

July 30/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years

If Under 1 Year

If Under 24 Hours

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18.

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 29, 1953, to July 30, 1953, that I last saw the deceased alive on July 30, 1953, and that death occurred at 1:05 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

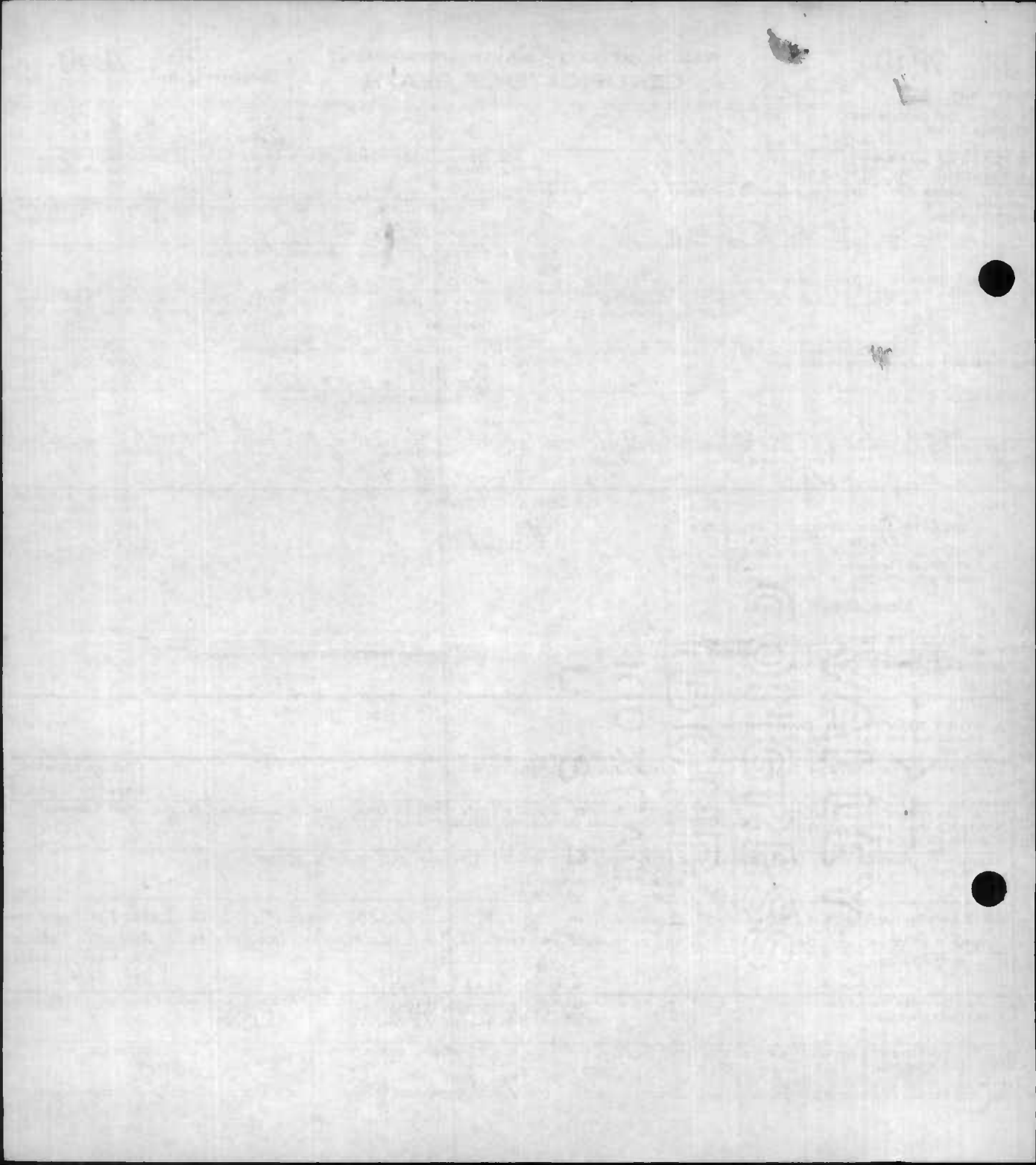
(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS





53 7041

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7041

BIRTH NO. 53-18254

1. NAME OF DECEASED  
(Type or Print)

BABY BOY COGAR

2. DATE  
OF  
DEATH

July 29/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Sinai Hospital*B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION*Sinai Hospital of Baltimore*

C. Length of stay in Baltimore

4 hrs 19 min

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

S

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

None

13. FATHER'S NAME

Cayroll Thomas Cogar

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL SECURITY NO.

None

B. DATE OF BIRTH

July 29/53

9. AGE (In years last birthday)

H Under 1 Year  
Months: DaysH Under 24 Hours  
Hours: Min.

4 49

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Lois Jacqueline Bagshaw

17. INFORMANT

mother

ADDRESS

18. 776X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Prematurity

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

4 hrs. 49 min.

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 29, 1953, to July 29, 1953, that I last saw the deceased alive on July 29, 1953, and that death occurred at 6:35 p.m., from the causes and on the date stated above.

23A. SIGNATURE

P. Schaffer

M. D.

23B. ADDRESS

Sinai Hospital

23C. DATE SIGNED

July 31/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

JOHN HOPKINS MEDICAL SCHOOL AUG 3 1953

DATE RECEIVED BY  
LOCAL REGISTRAR

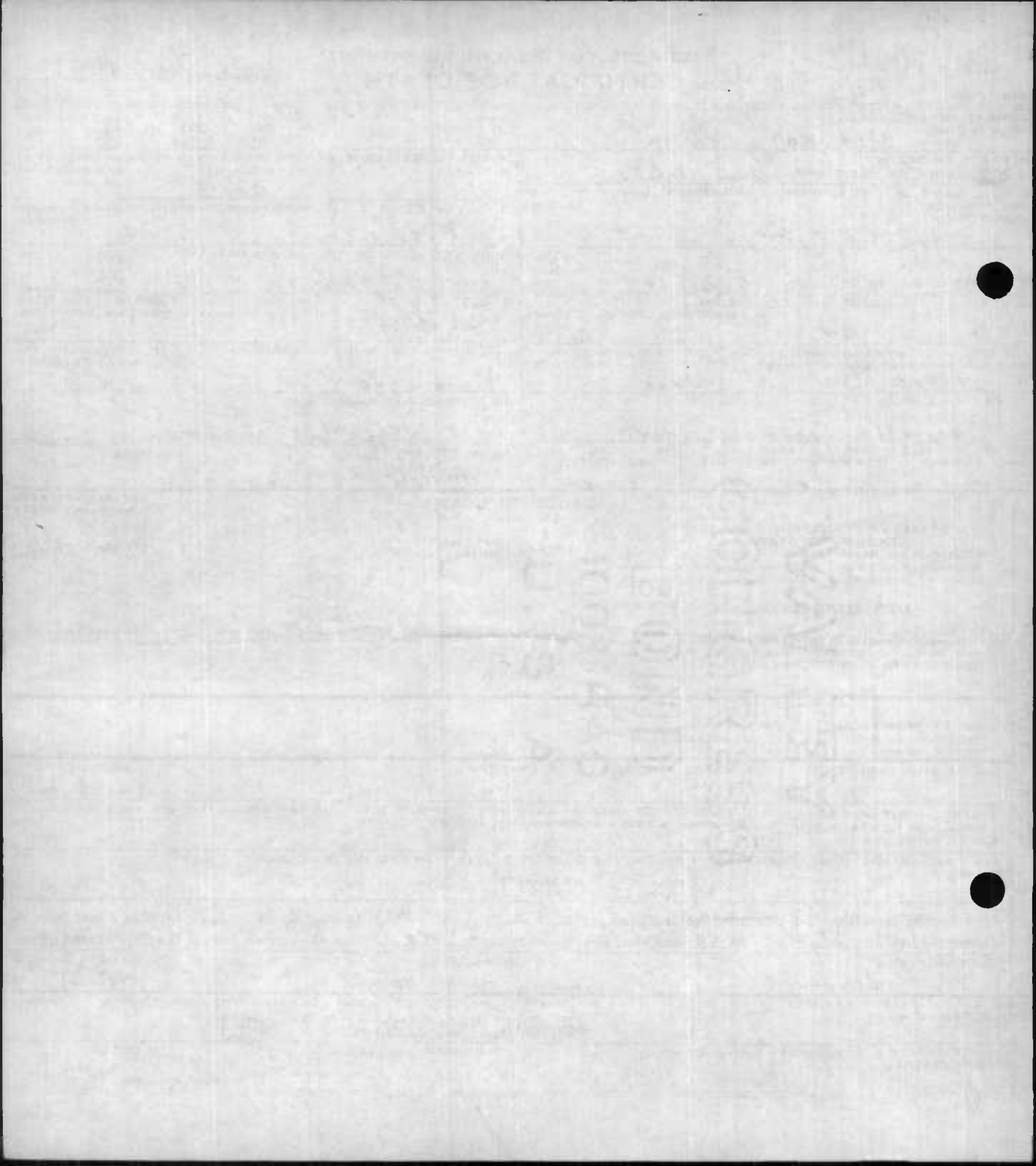
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Huntington Williams, M.D.



3-632  
53 7042BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7042  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Anna B. Bridge

2. DATE  
OF  
DEATH

Aug. 3, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION St Joseph Hospital  
1400 Blk N. Caroline St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

10-01

D. STREET ADDRESS (If rural, give location)

1021 Somerset St

C. Length of stay in Baltimore

69 - Yrs.  
11 - Mos.  
16 - Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Aug 13-1883

9. AGE (In years  
last birthday)

69

If Under 1 Year  
Months: Days

11 16

If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

House work

10B. KIND OF BUSINESS OR  
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Pentzgraph

14. MOTHER'S MAIDEN NAME

Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr George J Bridge 1021 Somerset St.

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Acute Coronary Infarction

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Ch Degenerative Cardio-Renal Disease

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

Ch Hypertension

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/4, 1952 to Apr 18, 1953 that I last saw the  
deceased alive on 4/18, 1953 and that death occurred at 2A .m., from the causes and on the date stated above.

23. SIGNATURE

A. S. Hornstein

M. D.

23B. ADDRESS

204 E. Biddle St

23C. DATE SIGNED

8/4/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

Aug 6, 1953

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cemetery

24D. LOCATION (City, town, or county)

Baltimore - Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Hall

25. FUNERAL DIRECTOR

ADDRESS

W. C. Conklin 824 E. Eager St

100

RECEIVED

100



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. **53 7043**

**F-436**  
BIRTH NO. **53 704353-15453**

1. NAME OF DECEASED (Type or Print) <b>Baby Boy Felder</b>		2. DATE OF DEATH <b>July 9, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>H. R. Penn</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md.</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 10-01</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>1423 E. Biddle St.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>7-7-53</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) Months: Days <b>2</b>
11. BIRTHPLACE (State or foreign country) <b>md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Paul Felder</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>JOHNS HOPKINS HOSPITAL</b>		ADDRESS	

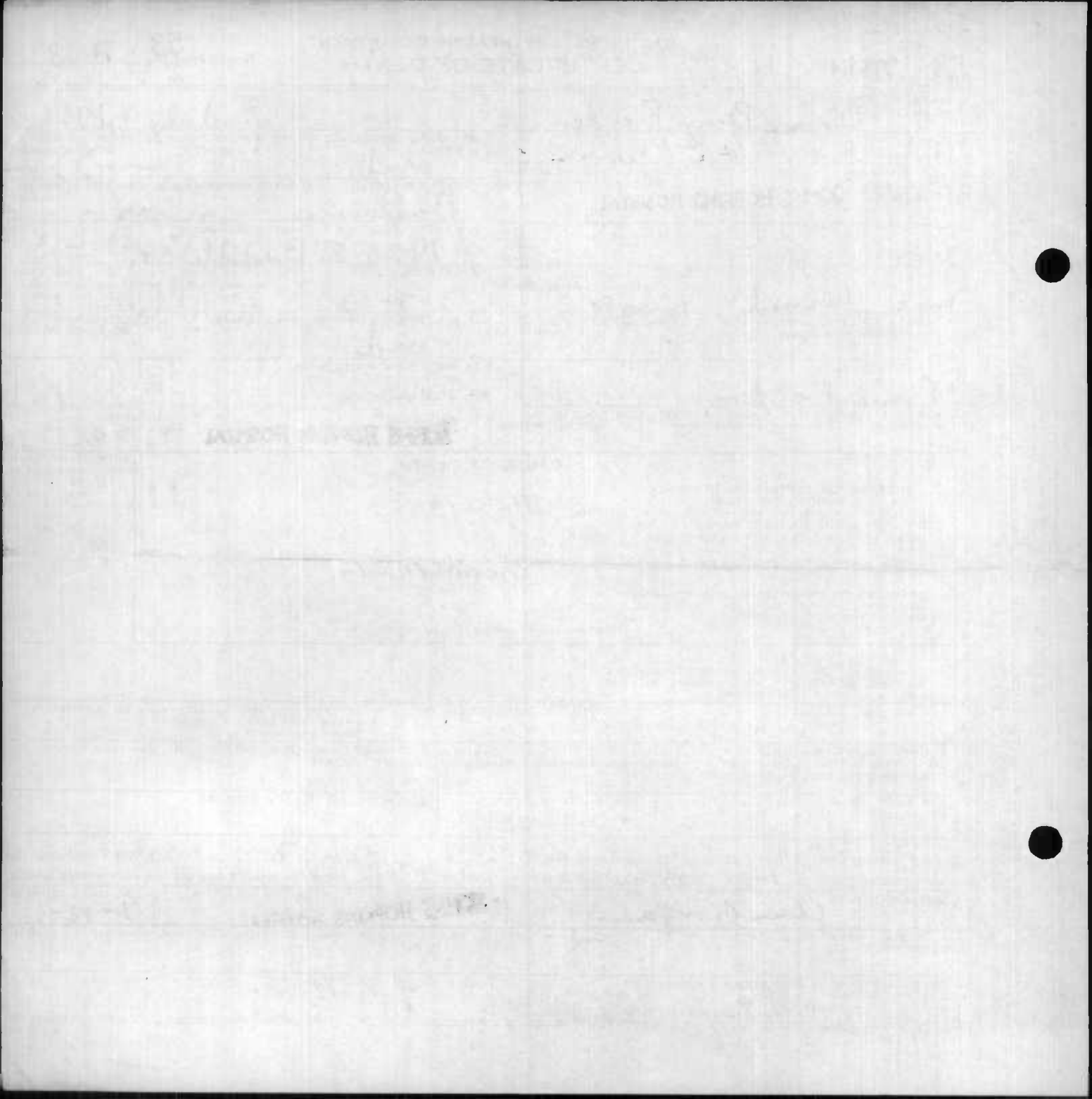
18. <b>762.5</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Atelectasis</b> DUE TO <b>Prematurity</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7-7**, 1953, to **7-9**, 1953, that I last saw the deceased alive on **7-9**, 1953, and that death occurred at **4:20 Pm.**, from the causes and on the date stated above.

23A. SIGNATURE **Ann Morgan** M. O. **JOHNS HOPKINS HOSPITAL** 23C. DATE SIGNED **7-12-53**

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 4 1953</b>	REGISTRAR'S SIGNATURE <b>Huntington</b>	25. FUNERAL DIRECTOR <b>W. B. Jones</b>	ADDRESS





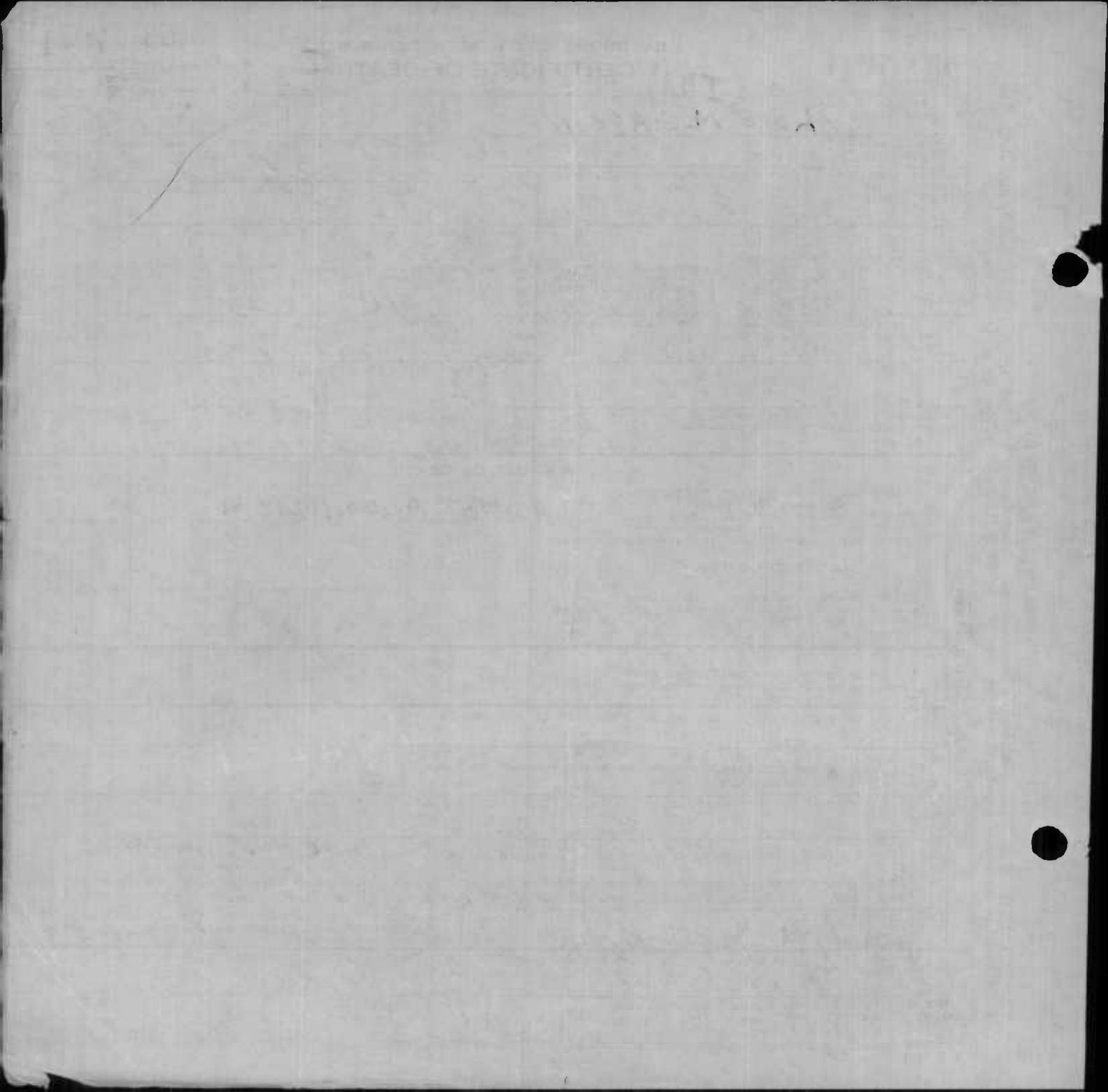
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-252

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7044  
Registered No.

53 7044 BIRTH NO.		ARDIE (IDA) ARDIE M. GASKINS		8-1-53 DATE OF DEATH	
1. NAME OF DECEASED (Type or Print)				2. DATE OF DEATH	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 238 Beal Ct.				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-05	
C. Length of stay in Baltimore 20 Yrs				D. STREET ADDRESS (If rural, give location) 238 Beal Ct.	
5. SEX F	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH 12/5/07		9. AGE (in years last birthday) 45
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Work		10B. KIND OF BUSINESS OR INDUSTRY Peoples Ser. Laundry		11. BIRTHPLACE (State or foreign country) Alexander, Va.	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Annie Thompson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 212-26-3580		17. INFORMANT ADDRESS Doris Johnson-1201 Dukeland St.	
18. 322.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ACUTE ALCOHOLISM (A) DUE TO				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES (B) DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <u>INSPECTION &amp; INQUIRY</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE Joseph A. Jachimczyk		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED 8-1-53	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/5/53		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park	
24D. LOCATION (City, town, or county) Balto. Co., Md.		24E. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		24F. LOCATION (City, town, or county) Balto. Co., Md.	
DATE RECEIVED BY LOCAL REGISTRAR AUG 4 1953		REGISTRAR'S SIGNATURE Huntington Williams		25. FUNERAL DIRECTOR Charles R. Law, 803 Mad. Ave.	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No.

53

7045

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Cornelius Washington

2. DATE  
OF  
DEATH

7/31/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
A. STATE B. COUNTY before admission)

Maryland

5. PLACE OF DEATH (If not in institution, give street address or  
HOSPITAL OR INSTITUTION)

1817 Madison Avenue 9/24/64

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 17, Maryland

D. STREET ADDRESS (If rural, give location)

1817 Madison Ave.

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

1/6/96

9. AGE (In years  
last birthday)

57

10. Under 1 Year  
Months Days

11. Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Porter

10B. KIND OF BUSINESS OR  
INDUSTRY

Sports Center

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

James Washington

14. MOTHER'S MAIDEN NAME

Unknown

Katie Hammond

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

220-05-1212

17. INFORMANT ADDRESS  
Myrtle Washington, 1817 Madison Ave.

18.

177X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Carcinoma tons

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Ca of Prostate

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

?

?

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONOITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 29, 1953, to July 31, 1953, that I last saw the  
deceased alive on July 31, 1953, and that death occurred at 4:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Signature

5309 2nd Hill Ave

8-3-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8/4/53

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Memorial Park

24D. LOCATION (City, town, or county)

Balto. Co., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Huntington

Charles R. Law, 802 Madison Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and in

Corrected by Marriage Record of deceased,  
1952 Withholding Statement, Voter's Card  
6-10-64 M.H.

Parent's names inserted from birth certificate of deceased.

9/25/64 C.Bowens

# CERTIFICATE OF DEATH

Registered No

2. DATE OF DEATH 8-3-53

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

C. CITY OR TOWN Bonnie If outside corporate limits, write RURAL and give townships

D. STREET ADDRESS (If rural, give location)

8. DATE OF BIRTH 7/28/53	9. AGE (In years last birthday)	If Under 1 Year Months: Days	If Under 24 Hours Hours: Min.
-----------------------------	------------------------------------	---------------------------------	----------------------------------

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME ~~Frank~~ Nellie Mobley

16. SOCIAL SECURITY NO.

17. INFORMANT	ADDRESS
Rector	Mike Donald

### CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(A) Post-op. Shock

DUE TO

(B) Intra-mesenteric Herniation

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION
1970-1971	1. The system is generally sound and well maintained. 2. The system is generally sound and well maintained. 3. The system is generally sound and well maintained.

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

IN. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 8/3, 1953 to           , 19  , that I last saw the deceased alive on 8/3, 1953, and that death occurred at 8/3/53 from the causes and on the date stated above.

23A. SIGNATURE

23b. ADDRESS	23c. DATE SIGNED
Mercy Hospital	8/3/53

24A. BURIAL, CREMATION/REMOVAL (Specify)

248) DATE

24C. NAME OF CEMETERY OR CREMATORY

246. LOCATION (City, town, or county), (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS \_\_\_\_\_

VS 150

CERTIFICATE OF DEATH

with 14-11-11  
14-11-11

14-11-11

14-11-11

14-11-11

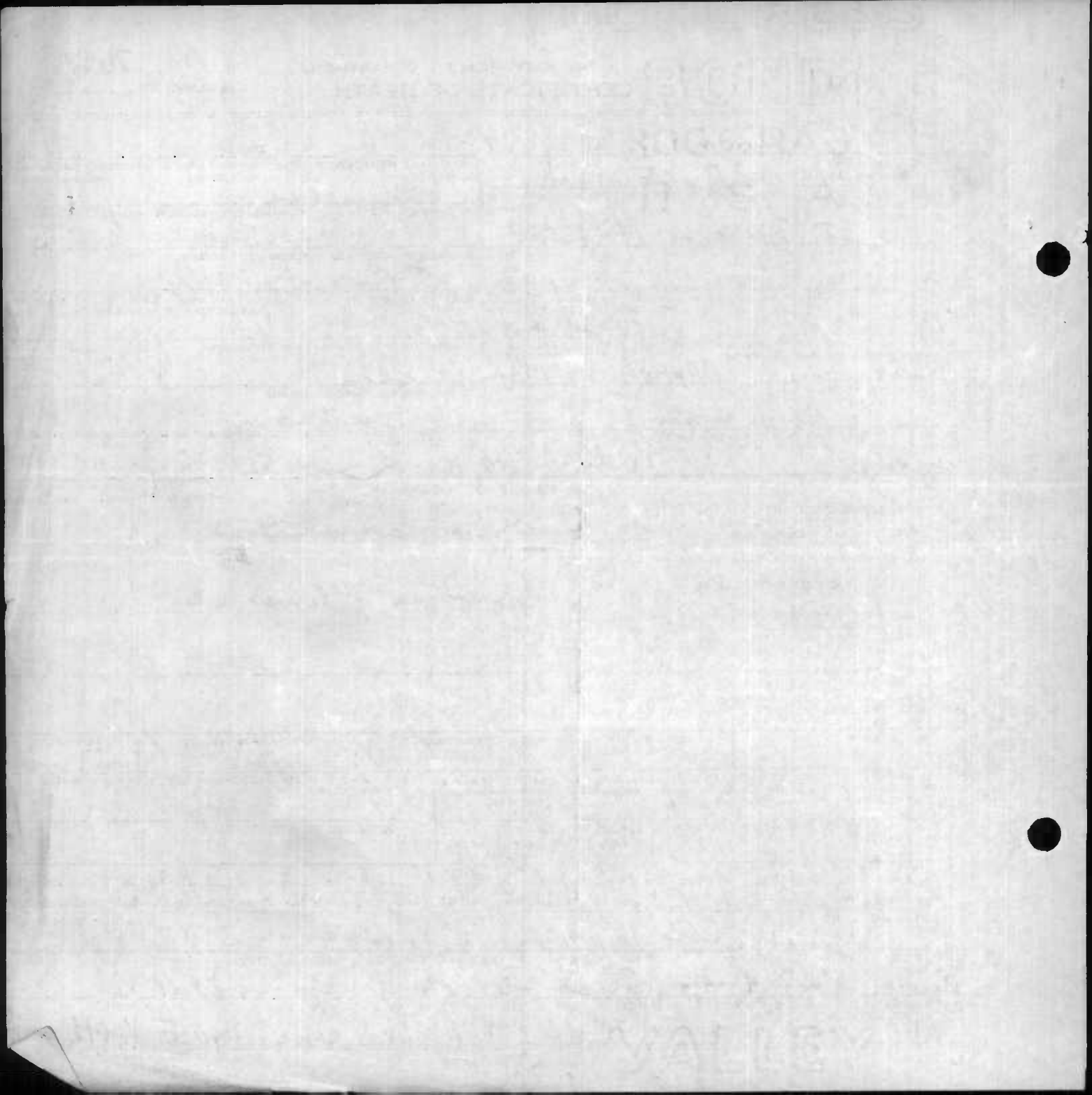


PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Z-516

53 7047  
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7047  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>Zoumberos, Stavros</b>		2. DATE OF DEATH <b>8-1-1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Balto. Md</b>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>St Agnes Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 2605</b>	
c. Length of stay in Baltimore <b>15 yrs</b> Yrs. <b>15</b> Mos. <b>0</b> Days <b>0</b>		D. STREET ADDRESS (If rural, give location) <b>542. Savage St</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>9-16-</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Merchant Mar</b>	9. AGE (In years last birthday) <b>44</b>
11. BIRTHPLACE (State or foreign country) <b>Greece</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>964-40-6397</b>	
17. INFORMANT <b>Mrs. Patras</b>		ADDRESS <b>515 S. Rappolla St.</b>	
18. <b>153X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Diffuse carcinomatous</b> DUE TO <b>carcinoma of lower colon</b>			INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 1, 1953</b> , to <b>Aug 1, 1953</b> , that I last saw the deceased alive on <b>Aug 1, 1953</b> , and that death occurred at <b>10<sup>48</sup> P.m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>James E. Rowe Jr. M. D.</b>		23B. ADDRESS <b>St. Agnes Hosp.</b>	23C. DATE SIGNED <b>8/1/53</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8-4-53</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Greek Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Windsor Mill Rd.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 4 1953</b>	REGISTRAR'S SIGNATURE <b>Huntington</b>	25. FUNERAL DIRECTOR <b>Kambros Inc.</b> ADDRESS <b>440 E. North Av.</b>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. **53 7048**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WALTER HILLIARD HALL

2. DATE  
OF  
DEATH

Aug. 2, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or  
location)HOSPITAL OR  
INSTITUTION

207 Church Warden Rd.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

207 Church Warden Rd.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug. 21, 1898

9. AGE (In years  
last birthday)

54

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Vice-Pres.

10B. KIND OF BUSINESS OR  
INDUSTRY

Pipe Covering

11. BIRTHPLACE (State or foreign country)

Clyde N. C.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Marcus L. Hall

14. MOTHER'S MAIDEN NAME

Lura Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

?

16. SOCIAL  
SECURITY NO.

?

17. INFORMANT

ADDRESS

Mrs. Mildred O. Hall

Above

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 10, 1953 to Aug 2, 1953, that I last saw the  
deceased alive on Aug 2, 1953, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Laurence C. Tash

M. O.

23B. ADDRESS

6805 York Rd

23C. DATE SIGNED

Aug. 3/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Removal

24B. DATE

8/4/53

24C. NAME OF CEMETERY OR CREMATORY

Bon-A-Venture Cem.

24D. LOCATION (City, town, or county) (State)

Canton, N. C.

DATE RECEIVED BY  
LOCAL REGISTRAR

AUG 4 1953

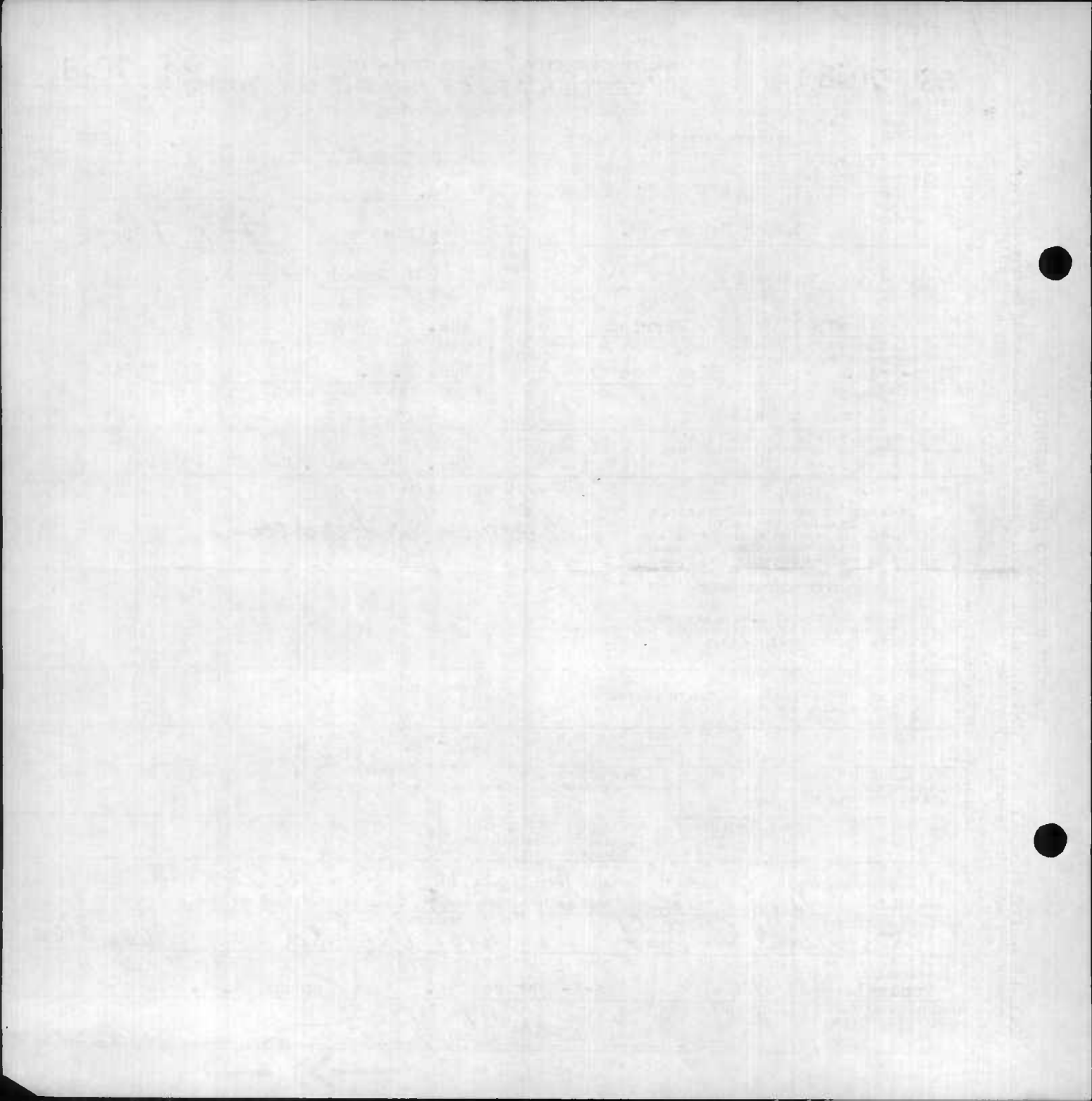
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wm. J. Tucker &amp; Sons Inc. Balto Md.

ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7049

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LANG, EDITH M.

2. DATE  
OF  
DEATH

8/31/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
INSTITUTION University Hospital4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY BaltimoreC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 24-04D. STREET ADDRESS (If rural, give location)  
443 E. Ant Ave

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

June 2, 1894

9. AGE (In years  
last birthday)

59

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
Home10B. KIND OF BUSINESS OR  
INDUSTRY  
Home11. BIRTHPLACE (State or foreign country)  
Martinsburg, W. Va.12. CITIZEN OF  
WHAT COUNTRY?  
USA

13. FATHER'S NAME

(Unknown) Boxwell

14. MOTHER'S MAIDEN NAME  
Laura Tabler15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)  
No16. SOCIAL  
SECURITY NO.  
No17. INFORMANT ADDRESS  
Mrs. John G. Butt 835 Woodington Rd.

18.

170X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Carcinoma of the breast, st. with  
generalized metastasis 2 yrs.

## ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

11

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Dec. '51

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

Carcinoma of breast

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/27, 1952, to 8/3, 1953, that I last saw the  
deceased alive on 8/3, 1953, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

H. J. Tabler

M. D.

23B. ADDRESS

University Hospital

23C. DATE SIGNED

8/3/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 6, 1953

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cemetery

24D. LOCATION (City, town, or county)

Baltimore Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

AUG 4 1953

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wm. J. Tabler &amp; Sons, Inc. Balt. Md.

ADDRESS





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7050

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7050

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CLARA B EVANS

2. DATE  
OF  
DEATH

Aug. 2, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2117 Chelsea Terrace

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

July 7, 1860

9. AGE (In years  
last birthday)

93

If Under 1 Year: Months: Days

If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Home

10B. KIND OF BUSINESS OR  
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Harford Co. Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas Johnson

14. MOTHER'S MAIDEN NAME

Elizabeth Barrow

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS

Mr. R. L. Evans 618 Allendale St.

18. 331X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) ...  
DUE TO

Cerebral hemorrhage

INTERVAL BETWEEN  
ONSET AND DEATH

3 days

## ANTECEDENT CAUSES

(B) ...  
DUE TO  
(C) ...DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office hldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/31, 1942, to 8/2, 1953, that I last saw the  
deceased alive on 8/2, 1953, and that death occurred at 4:55 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Robert A. Reiter

23B. ADDRESS

M. D.

3408 Windsor Ave

23C. DATE SIGNED

8/3/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8/4/53

24C. NAME OF CEMETERY OR CREMATORY

Greenmount Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

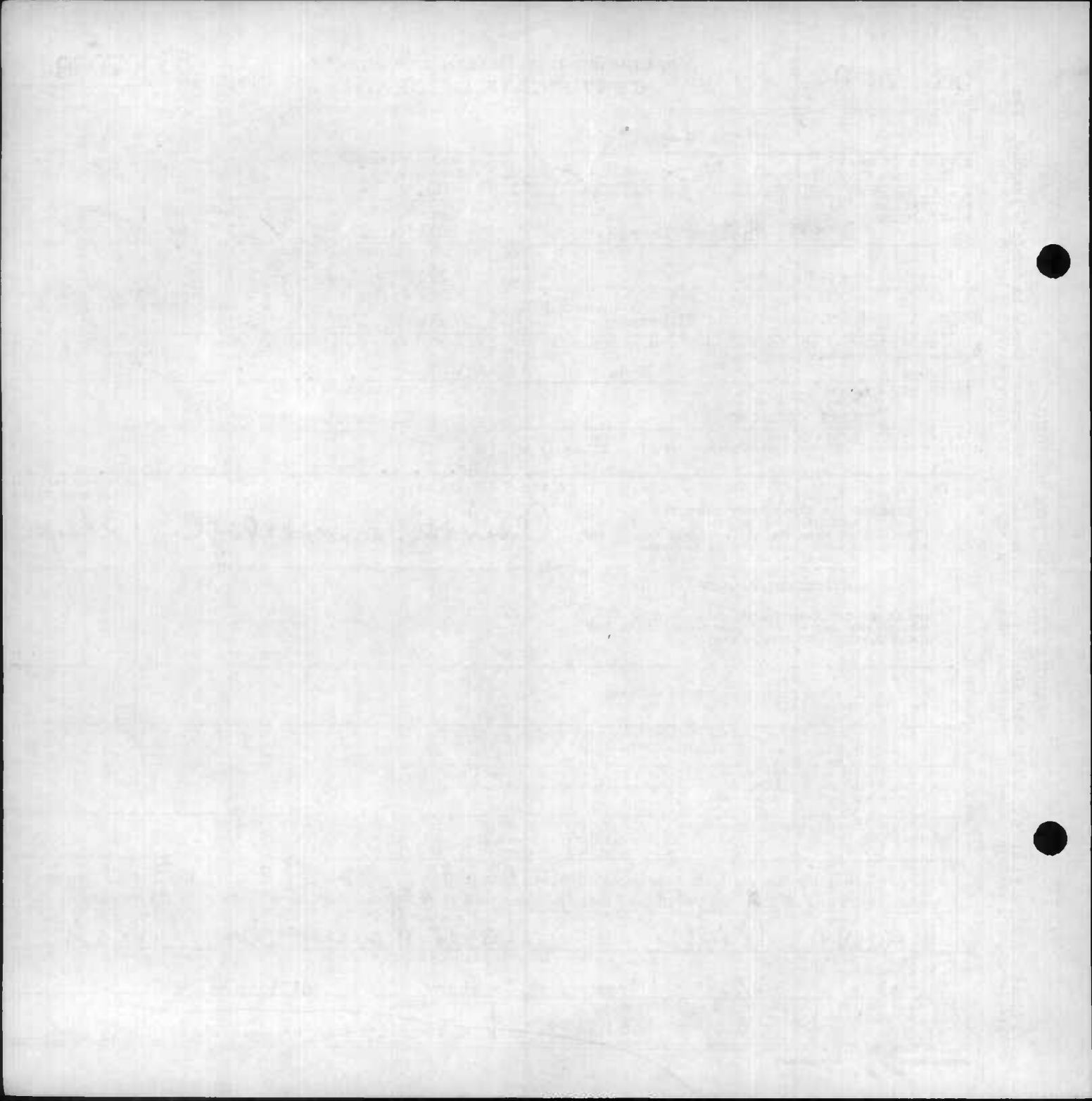
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 4 1953

Huntington Baltimore Md J. J. Tucker &amp; Sons Inc. Balt Md



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7051

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7051

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mr. Harry Orem

2. DATE  
OF  
DEATH

8.1.53

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY BaltimoreB. FULL NAME OF  
HOSPITAL OR  
INSTITUTIONSt. Agnes Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore, Maryland

D. STREET ADDRESS (If rural, give location)

3164 Wilkens Avenue #23

c. Length of stay in Baltimore

59 YrsYrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

Married

8. DATE OF BIRTH

5.159. AGE (In years  
last birthday)59

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)Pensioned10B. KIND OF BUSINESS OR  
INDUSTRYGAS. & ELECTRIC CO.

11. BIRTHPLACE (State or foreign country)

MARYLAND12. CITIZEN OF  
WHAT COUNTRY?USA

13. FATHER'S NAME

SAMUEL OREM

14. MOTHER'S MAIDEN NAME

SUSAN KINGLING15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)No16. SOCIAL  
SECURITY NO.212-05-5971

17. INFORMANT

Mrs. MARY M. OREM

ADDRESS

Ave.18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Pulmonary Embolism  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Hypertensive cardiovascular  
DUE TO congestive failure  
(C)II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 18, 1953, to Aug 1, 1953, that I last saw the  
deceased alive on Aug 1, 1953, and that death occurred at 11:45 am, from the causes and on the date stated above.

23A. SIGNATURE

James E Rowe Jr. M. D.

23B. ADDRESS

St Agnes Hosp.

23C. DATE SIGNED

8/1/5324A. BURIAL, CREMA-  
TION, REMOVAL (Specify)Burial

24B. DATE

8-5-1953

24C. NAME OF CEMETERY OR CREMATORY

London PARK

24D. LOCATION (City, town, or county)

BALTO. MARYLAND.

(State)

DATE RECEIVED BY  
LOCAL REGISTRARAUG 4 1953

REGISTRAR'S SIGNATURE

Huntington Williams, Jr.

25. FUNERAL DIRECTOR

St. Thomas Schwalb

ADDRESS

6905 E 3512 Frederick Ave.

7/11/11

CHARTER

100000

U. S.

100000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7052

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

53 7052  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Blanche Victoria Dixon

2. DATE  
OF  
DEATH

Aug. 3, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
MarylandB. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

2209 Bryant Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2209 Bryant Avenue

C. Length of stay in Baltimore

61 yrs.

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

Jan. 3, 1892

9. AGE (In years  
last birthday)

61

11 Under 1 Year  
Months: Days  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Beautician

10B. KIND OF BUSINESS OR  
INDUSTRY

Beauty Salon

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Howard Finks

14. MOTHER'S MAIDEN NAME

Elizabeth Skyler

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Rosetta Lewis-2209 Bryant Ave.

18.

331X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Cerebral Hemorrhage (left)

DUE TO

2 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Hypertension (Malignant)

DUE TO

6 mos

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH. ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-1, 1953, to 8-3, 1953, that I last saw the  
deceased alive on 8-3, 1953, and that death occurred at 7:04 a. m., from the causes and on the date stated above.

23. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

Aug. 6, 1953

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary

24D. LOCATION (City, town, or county) (State)

Baltimore Co., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 4 1953

Huntington Williams, M.D. Holland Funeral Home 1631 Grand Hill Ave.

SEA 7-14

RECEIVED 10/10/1964

0

10/10/1964

SEA 7-14

10/10/1964

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10/10/1964

10/10/1964



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7053

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7053

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Naomi Ruth Hare

2. DATE  
OF  
DEATH

Aug 1, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

1638 N. Smallwood St.

C. CITY OR TOWN (If outside corporate limits, write FULL and give township)

Baltimore 15-03

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

1638 N. Smallwood St.

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Feb. 1, 1902

9. AGE (In years last birthday)

51

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Paul J. Hudson

14. MOTHER'S MAIDEN NAME

Annie Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

1541 Pulaski St.

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Coronary Occlusion

## ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 29, 1953 to Aug 1, 1953, that I last saw the deceased alive on Aug 1, 1953, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Stanford P. Woodward, M.D.

23B. ADDRESS

2309 Druid Hill Ave

23C. DATE SIGNED

8-4-53

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial Aug. 4, 1953

Arbutus Mem. Pk. Balt. Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

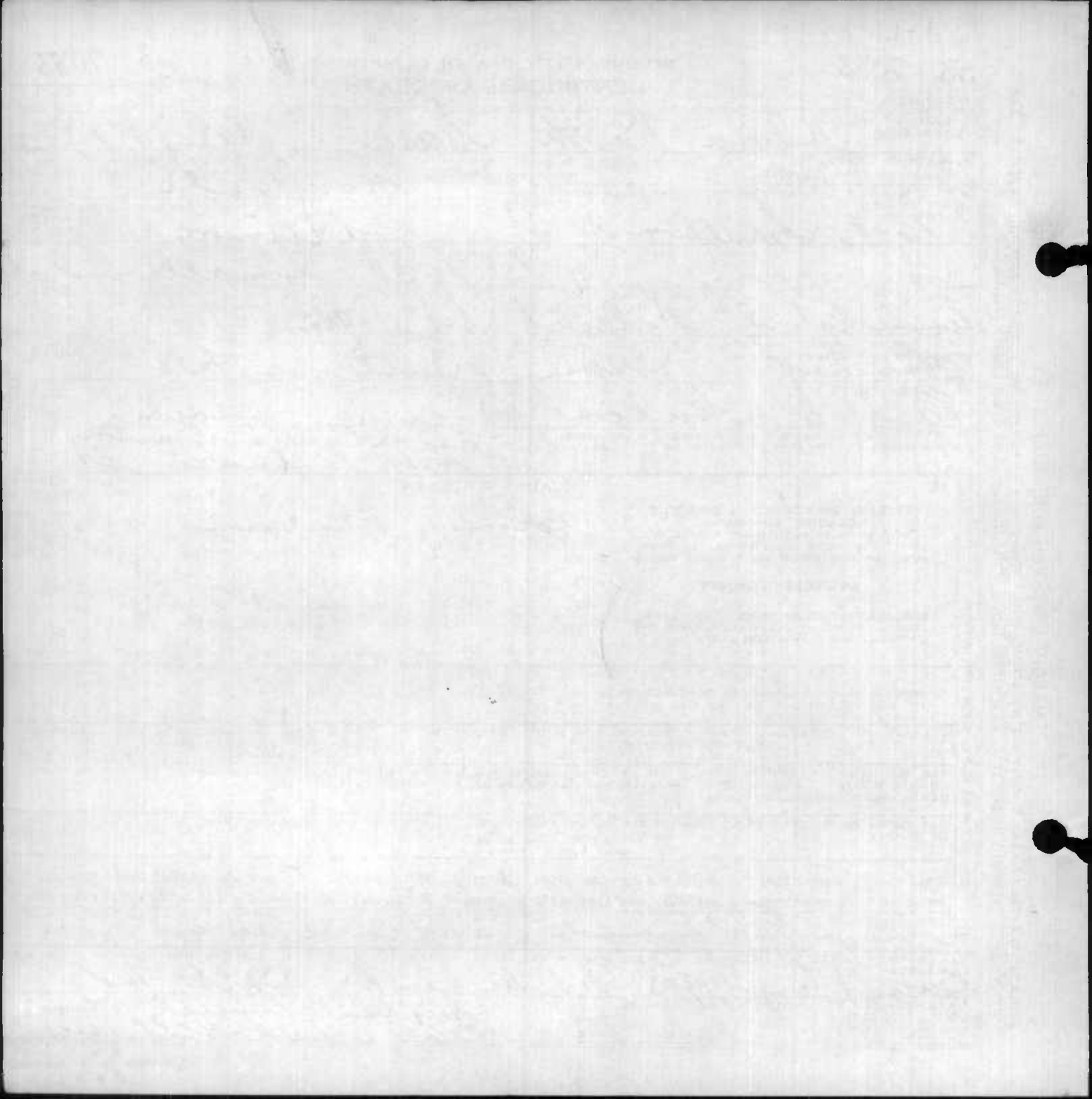
25. FUNERAL DIRECTOR (Name)

ADDRESS

AUG 4 1953

Huntington

1631 Druid Hill Ave.



8-650

53 7054

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7054

Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Edward Owen Green</i>		2. DATE OF DEATH <i>8/1/1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balto.</i>			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>1713 Moreland.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto. 15-03</i>			
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <i>1713 Moreland Ave</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>April 6, 1885</i>	9. AGE (in years last birthday) <i>68</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Calvert Co. Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Pinkney Green</i>		14. MOTHER'S MAIDEN NAME <i>Madora Edlen</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Emma Dorsey Moreland 1713</i>	
18. <i>450.0</i>		CAUSE OF DEATH <i>Arterio-Sclerosis</i>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		DUE TO			
ANTECEDENT CAUSES		DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>7-6</i> , 19 <i>52</i> , to <i>8-1</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>8-1</i> , 19 <i>53</i> , and that death occurred at <i>9 A.m.</i> , from the causes and on the date stated above.					
22A. SIGNATURE <i>Th. Donald Bando</i>		22B. ADDRESS <i>2445 Shiloh Hill Ave</i>		22C. DATE SIGNED <i>8-3-53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>8/3/53</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary</i>	
24D. LOCATION (City, town, or county) (State) <i>A.A. Co. Md.</i>		24E. NAME OF CEMETERY OR CREMATORY		24F. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 4 1953</i>		REGISTRAR'S SIGNATURE <i>Huntington H. Williams</i>		25. FUNERAL DIRECTOR ADDRESS <i>322 N. Schroeder St.</i>	



53 7055

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7055

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)2. DATE  
OF  
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

C. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

D. STREET ADDRESS (If rural, give location)

8. DATE OF BIRTH

9. AGE (in years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

Cerebro-Vascular Accident

8 hrs.

Hypertension

7

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/31, 1953, to 8/1, 1953, that I last saw the  
deceased alive on 7/31, 1953, and that death occurred at 1:20 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

68352

MEDICAL CERTIFICATION





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. **53 7056**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Agnes Jackson*  
*a 2*

2. DATE  
OF  
DEATH

*Aug. 2, 53*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE *Ind.*

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION *JOHNS HOPKINS HOSPITAL*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Baltimore - 17-01*

c. Length of stay in Baltimore

D. STREET ADDRESS (If rural, give location)  
*6298. Poca St.*

5. SEX

*Female Negro*

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
*Widower*

8. DATE OF BIRTH

*6-2-62*

9. AGE (In years last birthday)

*51*

10 Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Storekeeper*

10B. KIND OF BUSINESS OR INDUSTRY

*grocery*

11. BIRTHPLACE (State or foreign country)

*Ind*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*3*

14. MOTHER'S MAIDEN NAME

*7*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
*JOHNS HOPKINS HOSPITAL*

18. *171X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Uremia*

DUE TO

ANTECEDENT CAUSES

(B) *Bil. Hydronephrosis - Non Funct. Left Kidney*

DUE TO

(C) *Carcinoma of Cervix and Radiation Reaction*

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *July 13, 1953* to *Aug 2, 1953*, that I last saw the deceased alive on *Aug. 2, 1953* and that death occurred at *9-2 m.*, from the causes and on the date stated above.

23A. SIGNATURE

*R. J. Muntz*  
M. D.

23B. ADDRESS

*JOHNS HOPKINS HOSPITAL*

23C. DATE SIGNED

*8-2-53*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

*8/7/53*

24C. NAME OF CEMETERY OR CREMATORY

*Mt. Auburn*

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

*AUG 4 1953*

REGISTRAR'S SIGNATURE

*Huntington Hall*

25. FUNERAL DIRECTOR

*W. S. Halstead*

ADDRESS

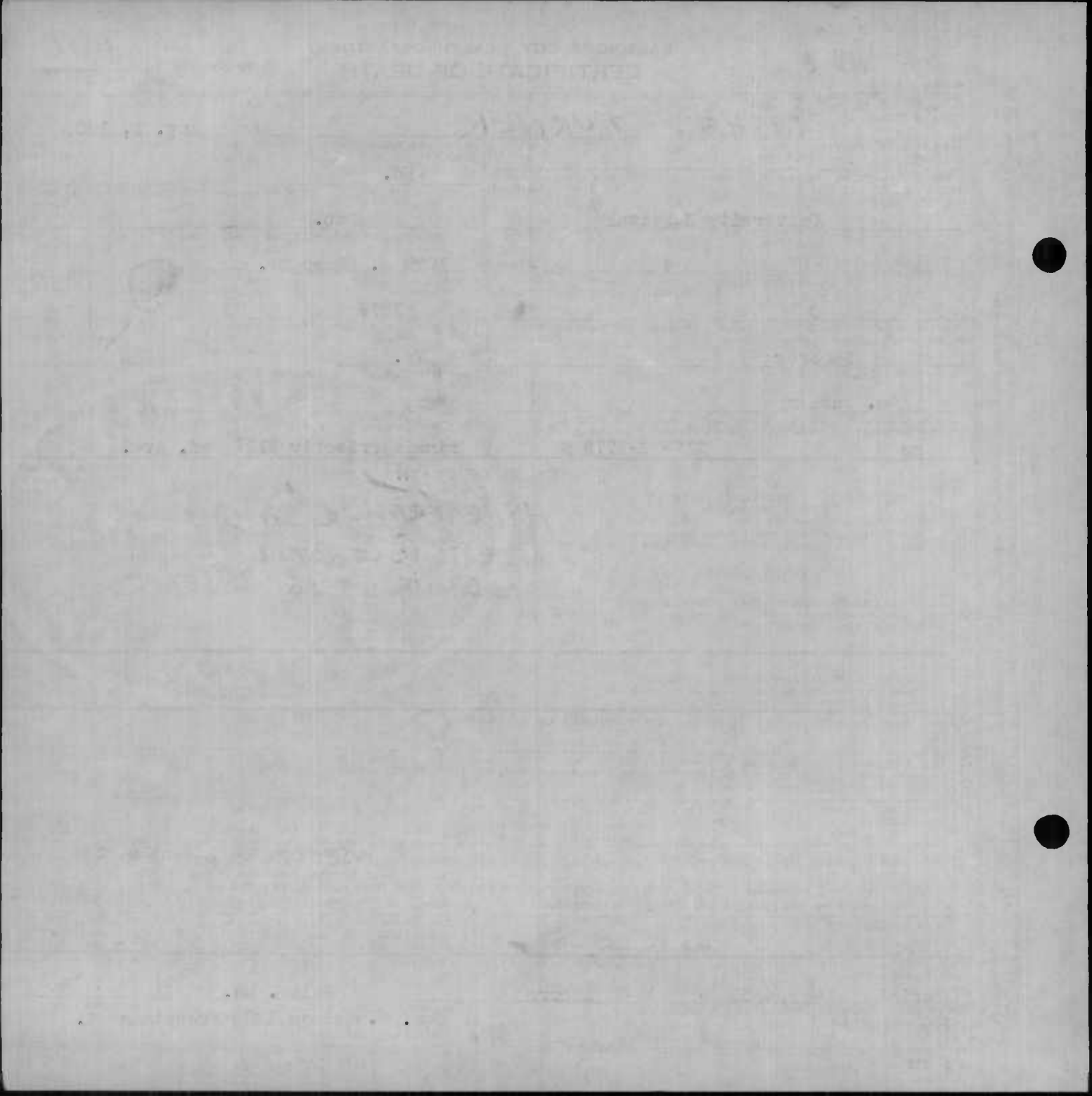
*918-*

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text is mirrored across the page.]*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				53 7057 Registered No.
BIRTH NO. <span style="float: right;">J-656 53 7057</span>				
1. NAME OF DECEASED (Type or Print) <b>RICHARD TURNER</b>			2. DATE OF DEATH <b>Aug. 1, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY	
5. FULL NAME OF (If not in hospital or institution, give street address or location) <b>University Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto. 23-01</b>	
c. Length of stay in Baltimore <b>?</b> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>1028 S. Sharp St.</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>W</b>	8. DATE OF BIRTH <b>1879</b>	9. AGE (In years last birthday) <b>73</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			11. BIRTHPLACE (State or foreign country) <b>Va.</b>	
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wm. Turner</b>			14. MOTHER'S MAIDEN NAME <b>Mary</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>217-03-3772 A</b>	
17. INFORMANT <b>Trinnie Prisetly</b>			ADDRESS <b>2117 Mad. Ave.</b>	
18. <b>443X</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>HYPERTENSIVE AND ARTERIO SCLEROTIC DISEASE</b> DUE TO (B) <b>CARDIOVASCULAR DISEASE</b> DUE TO (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an <b>INSPECTION</b> and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .				
23. SIGNATURE <b>Joseph A. Jachmes</b> M.D.		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>8-2-53</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8/4/53</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn</b>	24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 4 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington W. H. Jones</b>		25. FUNERAL DIRECTOR <b>Geo. S. Kelson</b> ADDRESS <b>1303 Presstman St.</b>
VS 151 <b>97099</b> <b>Geo. S. Kelson</b>				



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

William C. Doenges

2. DATE  
OF  
DEATH

Aug. 3, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland 210 N. Belnord Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY  
210 N. Belnord Ave. Balto. CityB. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto. Md.

D. STREET ADDRESS (If rural, give location)

210 N. Belnord Ave.

C. Length of stay in Baltimore

life

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 23, 1892

9. AGE (In years last birthday)

61

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Truck Driver

10B. KIND OF BUSINESS OR INDUSTRY

Hendler Ice Cream Co.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Frederick Doenges

14. MOTHER'S MAIDEN NAME

Elizabeth Irvin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

215-03-2875

17. INFORMANT

Mrs. Eliza May Doenges 210 N. Belnord Ave.

ADDRESS

18. 163X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1, 1953 to Aug 3, 1953, that I last saw the deceased alive on 11 A. M., 1953, and that death occurred at 12 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 6, 1953

24C. NAME OF CEMETERY OR CREMATORY

Trinity Cem.

24D. LOCATION (City, town, or county)

Balto. Md.

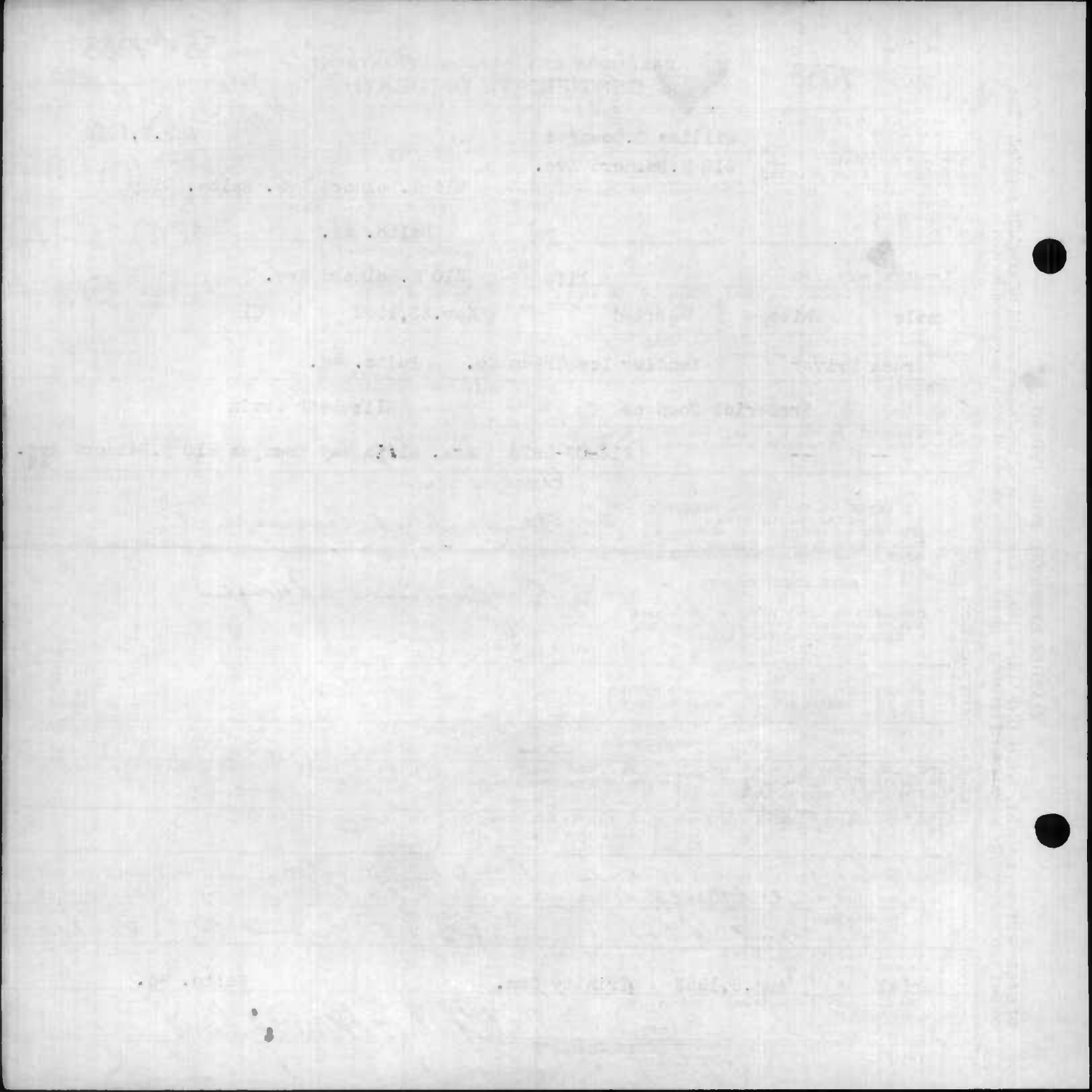
(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS





65-246  
53 7059BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHX  
Registered No. 53 7059

BIRTH NO.

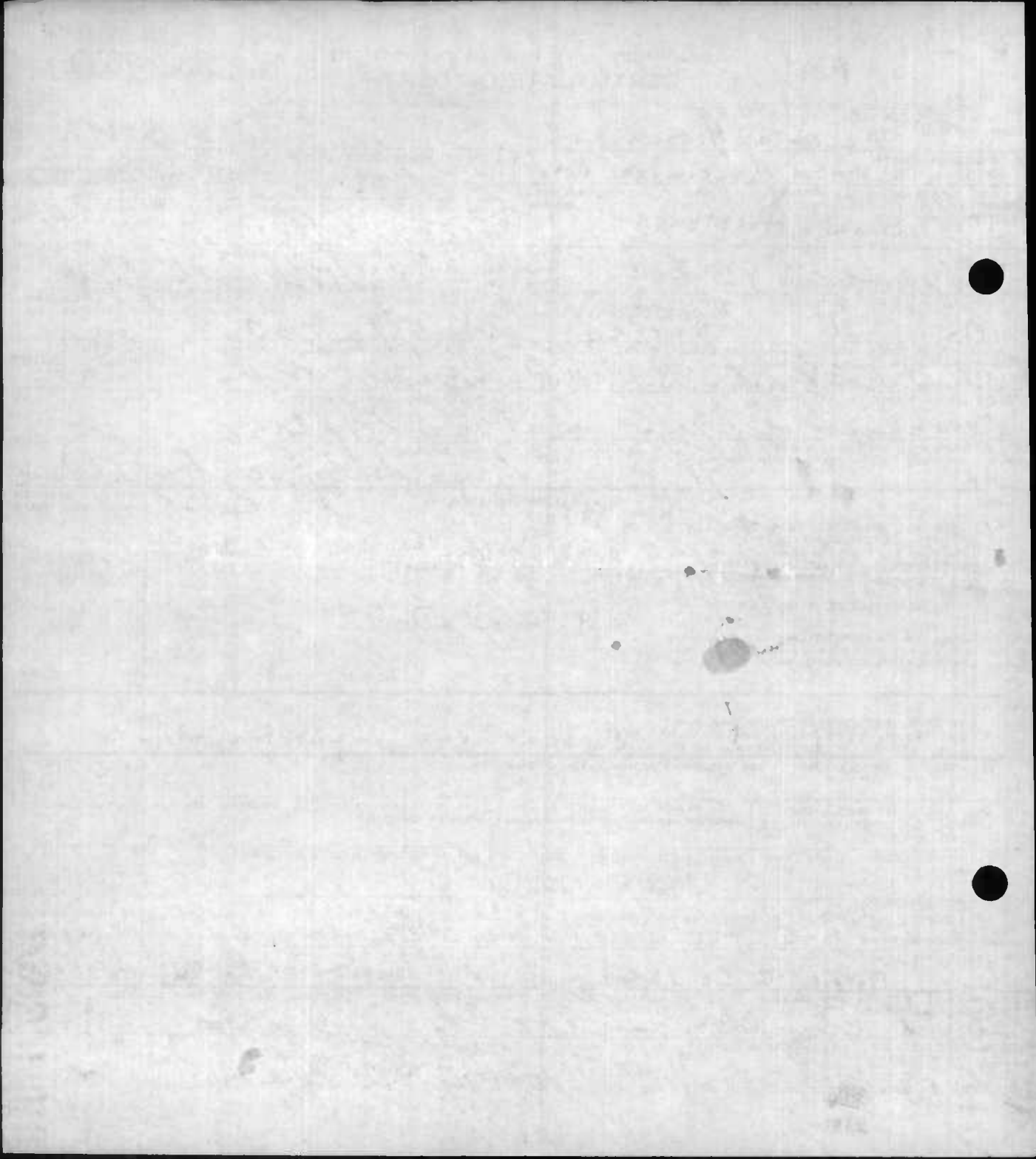
1. NAME OF DECEASED (Type or Print) <b>Melchior H. Schlerf</b>		2. DATE OF DEATH <b>8. 3. 1953.</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore City</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Catonsville 5352</b>	
D. STREET ADDRESS (If rural, give location) <b>2008 Rockwell Ave</b>		E. DATE OF BIRTH <b>Aug. 5/92</b>	
F. AGE (In years last birthday) <b>60</b>		G. Under 1 Year Months: Days: Hours: Min.	
H. Under 24 Hours		I. Under 1 Year	
J. Under 24 Hours		K. Under 1 Year	
L. Under 24 Hours		M. Under 1 Year	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Asst. Train Master, B. &amp; O. R.R.</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Melchior Schlerf</b>		14. MOTHER'S MAIDEN NAME <b>Rosa Mahr</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>2008 Rockwell Ave</b>	
17. INFORMANT <b>Mary E. Schlerf</b>		18. ADDRESS <b>2008 Rockwell Ave</b>	

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Vascular accident.</b>	CAUSE OF DEATH <b>Cat 28</b>	INTERVAL BETWEEN ONSET AND DEATH
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Myocardial infarction old.</b>		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>8. 3.</b> , 1953, to <b>8. 3.</b> , 1953, that I last saw the deceased alive on <b>8. 3.</b> , 1953, and that death occurred at <b>3:40 P.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Morris M. Goldberg M.D.</b>		23B. ADDRESS <b>Sinai Hospital Balto. Md.</b>		23C. DATE SIGNED <b>8. 3. 1953</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <b>Aug. 6/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Landon Pk.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 4 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>		25. FUNERAL DIRECTOR <b>Harry A. Krutzler</b>		ADDRESS <b>4101 Edmondson Ave</b>	

VS 150  
290 50



F-325  
53 7060BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7060  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Elizabeth A. Fitzmaurice</i>			2. DATE OF DEATH <i>8/4/53</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <i>Bon Secours Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>28-04</i>		
C. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>4506 Old Frederick Rd.</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>9/1/89</i>	9. AGE (In years last birthday) <i>63</i>	If Under 1 Year Months Days If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done, if any, and if retired) <i>housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Rockville Hotel</i>		
11. BIRTHPLACE (State or foreign country) <i>Balto</i>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Patrick Barnes</i>			14. MOTHER'S MAIDEN NAME <i>Mary Boylan</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Mr. Francis J. Fitzmaurice</i>			ADDRESS <i>Same</i>		

18. <i>157X and 260X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma, head of pancreas</i> DUE TO (A) <i>Carcinoma, head of pancreas</i> (B) (C) INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>	CAUSE OF DEATH
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Diabetes mellitus</i> DUE TO (A) (B) (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <i>7/28/53</i>	19B. MAJOR FINDINGS OF OPERATION <i>Carcinoma Head of Pancreas - metastases to Liver &amp; Gall Bladder</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>7/19, 1953</i> to <i>8/4, 1953</i> that I last saw the deceased alive on <i>8/4, 1953</i> and that death occurred at <i>2:45</i> a. m., from the causes and on the date stated above.		
23A. SIGNATURE <i>Robert Levine</i>	23B. ADDRESS <i>Bon Secours Hosp.</i>	23C. DATE SIGNED <i>8/4/53</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Aug. 7/53</i>	24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>	25. FUNERAL DIRECTOR <i>Harry H. Witzke</i>	ADDRESS <i>4101 Edmondson Ave.</i>

STATE OF NEW YORK  
CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Birth		6. Usual Residence		7. Cause of Death		8. Manner of Death	
9. Name of Physician		10. Name of Undertaker		11. Name of Burial Place		12. Name of Funeral Home	
13. Name of Coroner		14. Name of Medical Examiner		15. Name of Pathologist		16. Name of Anatomist	
17. Name of Registrar		18. Name of Clerk		19. Name of Nurse		20. Name of Embalmer	
21. Name of Burial Place		22. Name of Funeral Home		23. Name of Coroner		24. Name of Medical Examiner	
25. Name of Pathologist		26. Name of Anatomist		27. Name of Registrar		28. Name of Clerk	
29. Name of Nurse		30. Name of Embalmer		31. Name of Burial Place		32. Name of Funeral Home	
33. Name of Coroner		34. Name of Medical Examiner		35. Name of Pathologist		36. Name of Anatomist	
37. Name of Registrar		38. Name of Clerk		39. Name of Nurse		40. Name of Embalmer	
41. Name of Burial Place		42. Name of Funeral Home		43. Name of Coroner		44. Name of Medical Examiner	
45. Name of Pathologist		46. Name of Anatomist		47. Name of Registrar		48. Name of Clerk	
49. Name of Nurse		50. Name of Embalmer		51. Name of Burial Place		52. Name of Funeral Home	
53. Name of Coroner		54. Name of Medical Examiner		55. Name of Pathologist		56. Name of Anatomist	
57. Name of Registrar		58. Name of Clerk		59. Name of Nurse		60. Name of Embalmer	
61. Name of Burial Place		62. Name of Funeral Home		63. Name of Coroner		64. Name of Medical Examiner	
65. Name of Pathologist		66. Name of Anatomist		67. Name of Registrar		68. Name of Clerk	
69. Name of Nurse		70. Name of Embalmer		71. Name of Burial Place		72. Name of Funeral Home	
73. Name of Coroner		74. Name of Medical Examiner		75. Name of Pathologist		76. Name of Anatomist	
77. Name of Registrar		78. Name of Clerk		79. Name of Nurse		80. Name of Embalmer	
81. Name of Burial Place		82. Name of Funeral Home		83. Name of Coroner		84. Name of Medical Examiner	
85. Name of Pathologist		86. Name of Anatomist		87. Name of Registrar		88. Name of Clerk	
89. Name of Nurse		90. Name of Embalmer		91. Name of Burial Place		92. Name of Funeral Home	
93. Name of Coroner		94. Name of Medical Examiner		95. Name of Pathologist		96. Name of Anatomist	
97. Name of Registrar		98. Name of Clerk		99. Name of Nurse		100. Name of Embalmer	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAF-172670

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 53 7061

BIRTH No. 53 7061 53-17364

1. NAME OF DECEASED (Type or Print) <b>Baby Boy Jennings</b>		2. DATE OF DEATH <b>July 30, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>10-02</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>825 Aisquith St. zone 2</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>July 24, 1953</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>6</b> If Under 1 Year: Months: Days: Hours: Min.
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Gilbert Swilling</b>		14. MOTHER'S MAIDEN NAME <b>Ida Velma Jennings</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>B. C. H. 4940 Eastern Ave. (records)</b>
18. <b>763.5</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Aspiration Pneumonia</b> DUE TO ANTECEDENT CAUSES <b>Prematurity</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>7</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7-24</b> , 1953 to <b>7-30</b> , 1953, that I last saw the deceased alive on <b>7-30</b> , 1953, and that death occurred at <b>4:05P</b> m., from the causes and on the date stated above.			
23A. SIGNATURE <b>H. J. [Signature]</b>		23B. ADDRESS <b>4940 Eastern Ave., Balto., Md.</b>	23C. DATE SIGNED <b>7-30-1953</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremated</b>	24B. DATE <b>8-3-53</b>	24C. NAME OF CEMETERY OR CREMATORY <b>B. C. H. Crematory</b>	24D. LOCATION (City, town, or county) (State) <b>4940 Easter Ave.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 4 1953</b>	REGISTRAR'S SIGNATURE <b>H. J. [Signature]</b>	25. FUNERAL DIRECTOR <b>H. J. [Signature]</b>	ADDRESS <b>W. J. [Signature]</b>

10-11-1960

10-11-1960

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0-422  
53 7062

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7062  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>GEORGE Wojciech Olkowski</b>			2. DATE OF DEATH <b>Aug 4-1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Balto. City</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>106 S. Regester St.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto. City 7-02</b>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>106 S. Regester St.</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>April 22-1888</b>		9. AGE (In years last birthday) <b>65</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laboer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Building Trade</b>	11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Michael Olkowski</b>			14. MOTHER'S MAIDEN NAME <b>Katarzyna Kluga</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Bronislaw Olkowski 106 S. Regester St</b>		

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH (A) <b>Acute Myocardial Failure</b> DUE TO	INTERVAL BETWEEN ONSET AND DEATH <b>14 hrs</b>
	(B) <b>Hypertensive + arteriosclerosis</b> DUE TO	<b>2 yrs</b>
	(C) <b>Chronic Bronchitis</b> DUE TO	<b>3-5 yrs</b>

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  
**no**

19A. DATE OF OPERATION <b>no</b>		19B. MAJOR FINDINGS OF OPERATION <b>no</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <b>no</b>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Aug 3, 1953** to **Aug 4, 1953** that I last saw the deceased alive on **Aug 4, 1953**, and that death occurred at **5:30 PM**, from the causes and on the date stated above.

23A. SIGNATURE <b>M. Miller</b>	23B. ADDRESS <b>1663 E. Bolton</b>	23C. DATE SIGNED <b>8/4/53</b>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Aug. 7-1953</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary</b>	24D. LOCATION (City, town, or county) (State) <b>Balto. Co Md.</b>
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DATE RECEIVED BY LOCAL REGISTRAR <b>Aug 1953</b>	REGISTRAR'S SIGNATURE <b>Huntington</b>	25. FUNERAL DIRECTOR <b>Mr. S. Fialkowski</b>	ADDRESS <b>2007 Eastern Ave</b>
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97024

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race	
4. Date of birth		5. Date of death		6. Place of death	
7. Usual residence		8. Cause of death		9. Manner of death	
10. Signature of physician		11. Signature of medical examiner		12. Signature of coroner	
13. Signature of registrar		14. Signature of funeral director		15. Signature of undertaker	
16. Signature of witness		17. Signature of witness		18. Signature of witness	
19. Signature of witness		20. Signature of witness		21. Signature of witness	
22. Signature of witness		23. Signature of witness		24. Signature of witness	
25. Signature of witness		26. Signature of witness		27. Signature of witness	
28. Signature of witness		29. Signature of witness		30. Signature of witness	
31. Signature of witness		32. Signature of witness		33. Signature of witness	
34. Signature of witness		35. Signature of witness		36. Signature of witness	
37. Signature of witness		38. Signature of witness		39. Signature of witness	
40. Signature of witness		41. Signature of witness		42. Signature of witness	
43. Signature of witness		44. Signature of witness		45. Signature of witness	
46. Signature of witness		47. Signature of witness		48. Signature of witness	
49. Signature of witness		50. Signature of witness		51. Signature of witness	
52. Signature of witness		53. Signature of witness		54. Signature of witness	
55. Signature of witness		56. Signature of witness		57. Signature of witness	
58. Signature of witness		59. Signature of witness		60. Signature of witness	
61. Signature of witness		62. Signature of witness		63. Signature of witness	
64. Signature of witness		65. Signature of witness		66. Signature of witness	
67. Signature of witness		68. Signature of witness		69. Signature of witness	
70. Signature of witness		71. Signature of witness		72. Signature of witness	
73. Signature of witness		74. Signature of witness		75. Signature of witness	
76. Signature of witness		77. Signature of witness		78. Signature of witness	
79. Signature of witness		80. Signature of witness		81. Signature of witness	
82. Signature of witness		83. Signature of witness		84. Signature of witness	
85. Signature of witness		86. Signature of witness		87. Signature of witness	
88. Signature of witness		89. Signature of witness		90. Signature of witness	
91. Signature of witness		92. Signature of witness		93. Signature of witness	
94. Signature of witness		95. Signature of witness		96. Signature of witness	
97. Signature of witness		98. Signature of witness		99. Signature of witness	
100. Signature of witness		101. Signature of witness		102. Signature of witness	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **53 7063**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print) *Margaret Willis*

2. DATE  
OF  
DEATH *August 3, 1953*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *H.H. O.P. Dept*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE *md.*

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION *JOHNS HOPKINS HOSPITAL*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore*

D. STREET ADDRESS (If rural, give location)

*344 Calvert St. Camel St.*

c. Length of stay in Baltimore *?*

Yrs.  
Mos.  
Days

5. SEX

*Female*

6. COLOR OR RACE

*Colored*

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

*Single*

8. DATE OF BIRTH

*5/14/44*

9. AGE (In years  
last birthday)

*9*

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

*Student*

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

*N. C.*

12. CITIZEN OF  
WHAT COUNTRY?

*USA*

13. FATHER'S NAME

*Curtis Jenkins*

14. MOTHER'S MAIDEN NAME

*Laura Jenkins*

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, unknown) (If yes, give war or dates of service)

*no*

16. SOCIAL  
SECURITY NO.

17. INFORMANT *JOHNS HOPKINS HOSPITAL*

18.

*340.1*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A) *Capillaria Hepatica*  
DUE TO

ANTECEDENT CAUSES

(B) *Cirrhosis of liver*  
DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C) *Meningitis*

INTERVAL BETWEEN  
ONSET AND DEATH

*2 yrs*

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY

*William H. [Signature]*  
MEDICAL EXAMINER

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH. ENTER IN  
PART I OR PART II

20. AUTOPSY?  
YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *July*, 195*3*, to *July*, 195*3*, that I last saw the  
deceased alive on *July*, 19*53*, and that death occurred at *D.O.A.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Thomas E. Rachelder*

M. D.

23B. ADDRESS

*JOHNS HOPKINS HOSPITAL*

23C. DATE SIGNED

*8/3/53*

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

*Burial*

24B. DATE

*8/6/53*

24C. NAME OF CEMETERY OR CREMATORY

*Greenville*

24D. LOCATION (City, town, or county) (State)

*Greenville, N. C.*

DATE RECEIVED BY  
LOCAL REGISTRAR

*AUG 4 1953*

REGISTRAR'S SIGNATURE

*Huntington Williams, M.D.*

25. FUNERAL DIRECTOR

*Geo. G. Nelson 1303 Presstman St.*

ADDRESS

VS. 150

*Medical Examiners Case released to Hospital*

Pneumococcal Meningitis  
Diagnosis

From Report Card

5-350  
53 7064BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7064

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

MOLLIE APOLNIA STAHM

2. DATE  
OF  
DEATH

8/4/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland BALTIMORE

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

HOME

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

BALTIMORE 27-03

D. STREET ADDRESS (If rural, give location)

2908 SHIREY AVE

c. Length of stay in Baltimore

81- Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

6/16/72

9. AGE (In years  
last birthday)

81

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

H W

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF  
WHAT COUNTRY?

U. S.

13. FATHER'S NAME

Frederick Pfeffer

14. MOTHER'S MAIDEN NAME

Katherine Dammeyer

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

NONE

17. INFORMANT

Katherine M. Pfeffer 2908 Shirey Ave

ADDRESS

18. 420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Atherosclerosis heart disease  
DUE TO

1949

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO  
(C) \_\_\_\_\_II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1946, 19, to 8/4, 1953, that I last saw the  
deceased alive on 8/1/53, 19, and that death occurred at 3:20 PM, from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

4331 Harford Rd

23C. DATE SIGNED

8/4/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

Aug 7, 1953

24C. NAME OF CEMETERY OR CREMATORY

BALTIMORE CEMETERY

24D. LOCATION (City, town, or county)

BALTIMORE MD

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

1953 Huntington W. B. B. Co. Inc. Balt MD

Wm. J. Jackson &amp; Sons Inc. Balt MD

STATE OF NEW YORK  
COUNTY OF DEWITT

Know all men by these presents, that I, the undersigned, for and in behalf of the State of New York, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the County of DeWitt.

Witness my hand and the seal of the County of DeWitt, this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

\_\_\_\_\_  
County Clerk of DeWitt

\_\_\_\_\_  
Notary Public for the State of New York

\_\_\_\_\_  
Notary Public for the State of New York

\_\_\_\_\_  
Notary Public for the State of New York

\_\_\_\_\_  
Notary Public for the State of New York

\_\_\_\_\_  
Notary Public for the State of New York



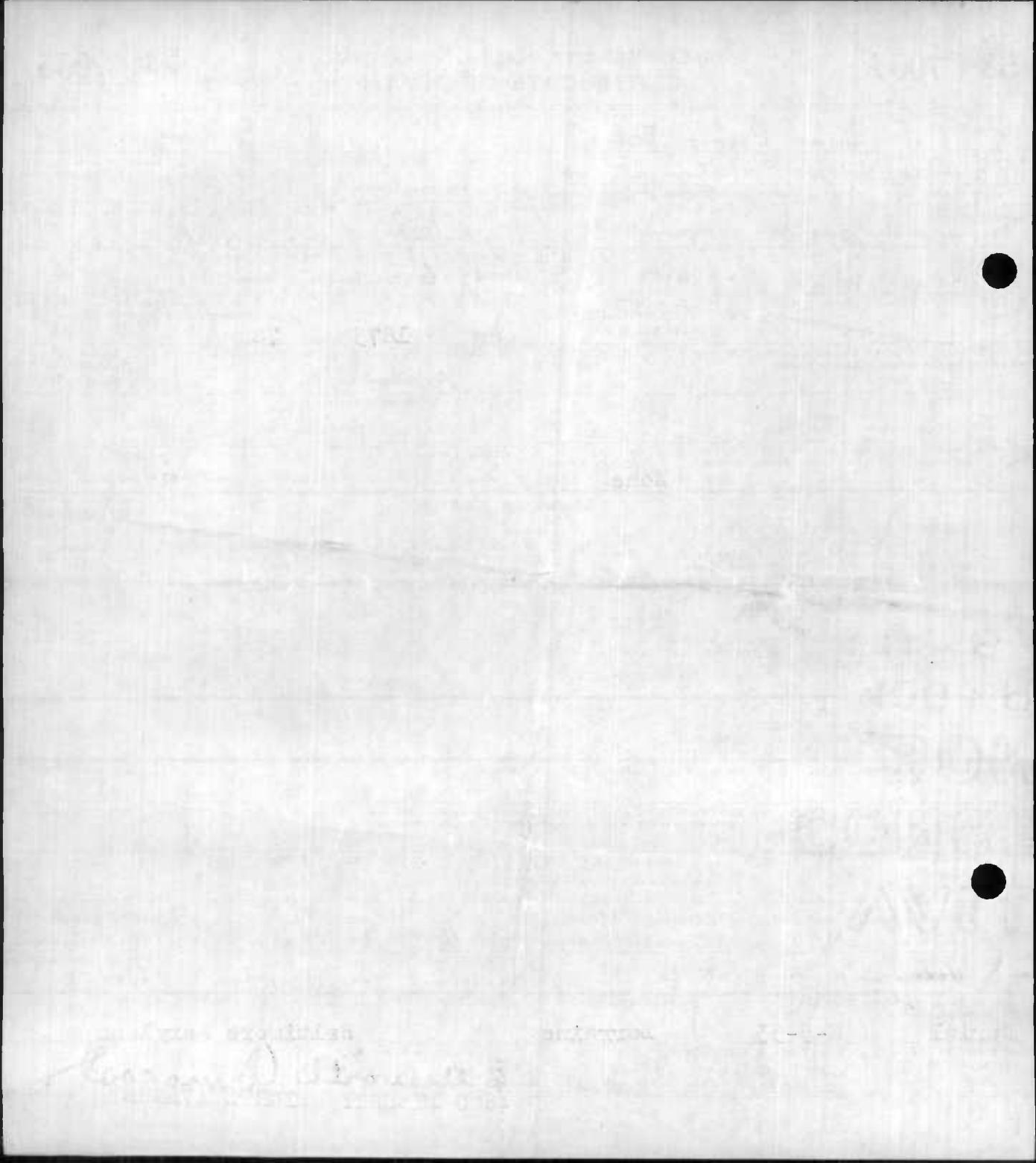
7-160  
53 7065

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7065

BIRTH NO.			1. NAME OF DECEASED (Type or Print) <i>Josephine Roerig Tober</i>			2. DATE OF DEATH <i>Aug. 3, 1953</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore, Md.</i>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY					
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>28-41</i>					
C. Length of stay in Baltimore <i>43 yrs.</i>			D. STREET ADDRESS (If rural, give location) <i>4806 Haddon Ave #7</i>					
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Jan 16 1875</i>		9. AGE (In years last birthday) <i>78</i>	10. Under 1 Year Months: Days		11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>			10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Barthold Roerig</i>			14. MOTHER'S MAIDEN NAME <i>Marie Schaller</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>None</i>			17. INFORMANT ADDRESS <i>Agnes Anderson 4806 Haddon Ave #7</i>		
18. <i>443X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>H.E.U.D. with decompensation</i> DUE TO CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>								
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.								
19A. DATE OF OPERATION <i>0</i>			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>8/1</i> , 19 <i>53</i> , to <i>8/3</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>8/3</i> , 19 <i>53</i> , and that death occurred at <i>1:30 P.M.</i> , from the causes and on the date stated above.								
23A. SIGNATURE <i>Valeriana B. Castillo</i>			23B. ADDRESS <i>M.D. Maryland Gen. Hospital</i>			23C. DATE SIGNED <i>8/3/53</i>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>8-5-53</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Lorraine</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 4 1953</i>			REGISTRAR'S SIGNATURE <i>Huntington W. ...</i>			25. FUNERAL DIRECTOR ADDRESS <i>E. ... 4600 LIBERTY HEIGHTS AVENUE</i>		

MEDICAL CERTIFICATION



W-656  
53 7066BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7066  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Eva Stewart Warner

2. DATE  
OF  
DEATH

August 1, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION 2520 W. Fayette St.,

D. STREET ADDRESS (If rural, give location)

2520 W. Fayette St., 20-02

c. Length of stay in Baltimore

72-Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Feb. 24, 1881

9. AGE (In years last birthday)

72

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House-wife

10B. KIND OF BUSINESS OR INDUSTRY

--

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Francis W. Orrell

14. MOTHER'S MAIDEN NAME

Florence Stewart

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (if yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

ADDRESS

Richard B. Orrell 2550 W. Fayette St.

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Coronary Thrombosis

ANTECEDENT CAUSES

(B)

DUE TO

Arterio sclerotic Cardio Vasc. Dis.

(C)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Generalized Arterio sclerotic

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH. ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., In or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐  
WORKNOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-31, 1953, to 8-1, 1953 that I last saw the deceased alive on 8-1, 1953, and that death occurred at 9:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Joseph Deepelbaum M.D.

M. D.

23B. ADDRESS

4017 Liberty Hgts. Ave.

23C. DATE SIGNED

8-3-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8-5-1953

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore,

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Walcott, M.D.

25. FUNERAL DIRECTOR

ADDRESS

G. Howard Strong 3207 W. North Ave.,

Dr. Jos. Deibelmann

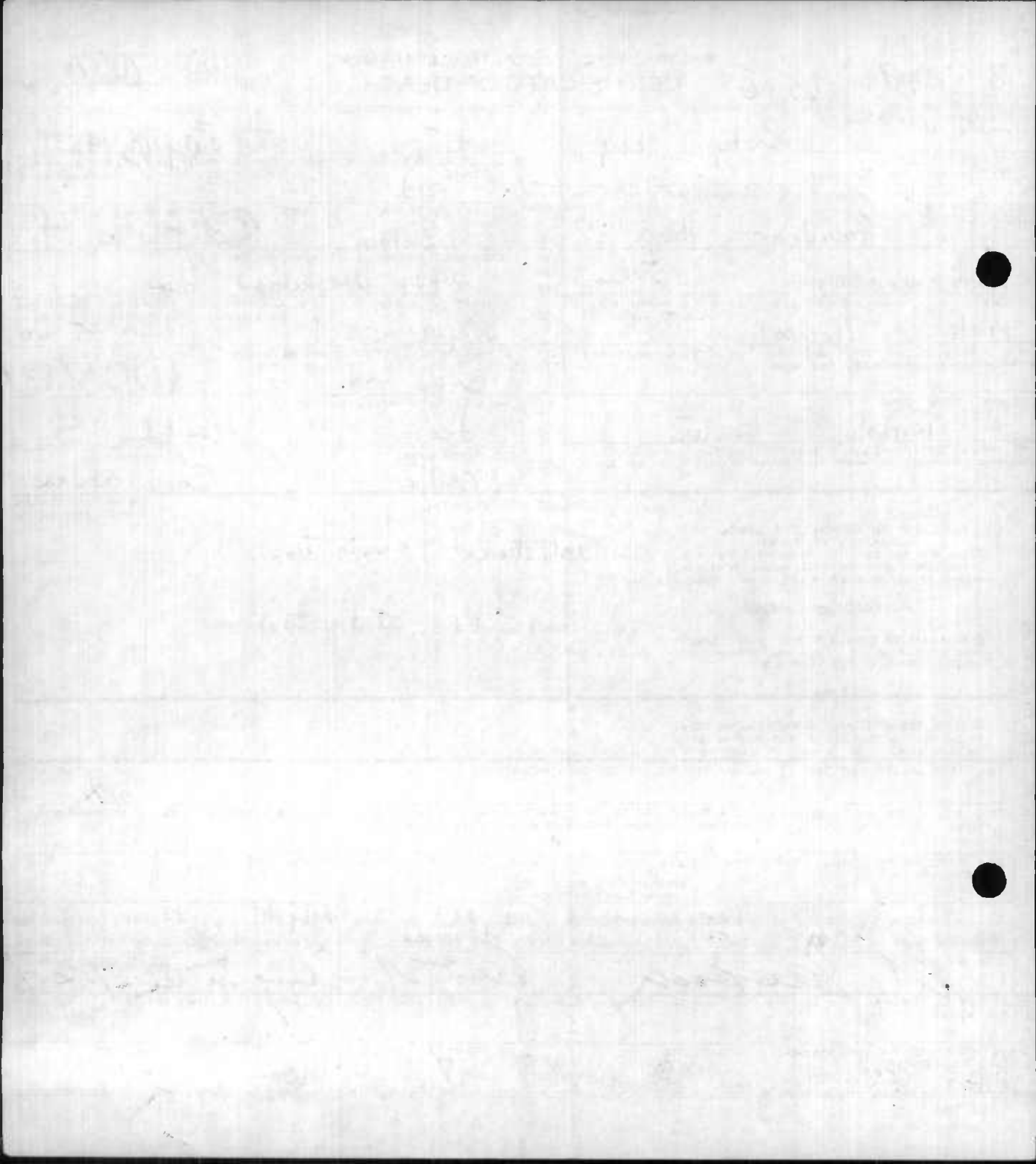
4017 Let. 2/100. No. 43865

3-320

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7067  
Registered No.

53 7067 BIRTH NO. 33-16586		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		53 7067 Registered No.	
1. NAME OF DECEASED (Type or Print) Baby boy		Bates		2. DATE OF DEATH July 19, 1953	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE md. B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION 37 Provident Hosp.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 15-06			
c. Length of stay in Baltimore 5 hrs		D. STREET ADDRESS (If rural, give location) 2941 Westwood Ave			
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH July 19, 1953	9. AGE (In years last birthday) 5 20
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto, md.	
13. FATHER'S NAME Temple Bates		14. MOTHER'S MAIDEN NAME Leola Boyd		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother ADDRESS Same address	
18. 762.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Intestinal obstruction DUE TO ANTECEDENT CAUSES Congenital atelectasis DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 7		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 19, 1953, to July 19, 1953, that I last saw the deceased alive on 7-19, 1953, and that death occurred at 10:40 a.m., from the causes and on the date stated above.					
23A. SIGNATURE M. Jackson		23B. ADDRESS 605 N. Liberty St.		23C. DATE SIGNED 7-20-53	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY Hemp Hill	
24D. LOCATION (City, town, or county)		24E. FUNERAL DIRECTOR Huntington		24F. ADDRESS	
DATE RECEIVED BY LOCAL REGISTRAR AUG 5 1953		REGISTRAR'S SIGNATURE Huntington		25. FUNERAL DIRECTOR Huntington	

MEDICAL CERTIFICATION





H-640

53 7068

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7068  
Registered No.

BIRTH NO. 53-15638

1. NAME OF DECEASED  
(Type or Print)

Baby boy Harley

2. DATE  
OF  
DEATH

July 8, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

37 Inocident Hospital

C. Length of stay in Baltimore

Shirley Min

Yrs.  
Mos.  
Days

5. SEX

m

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Alexander Harley

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

July 8, 1953

9. AGE (in years last birthday)

11 Under 1 Year Months: Days 11 Under 24 Hours Hours: Min.

8 45

11. BIRTHPLACE (State or foreign country)

Baltimore, md

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Alice McColl

17. INFORMANT

Mother

ADDRESS

18. 762.5

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

asphyxia

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

9 hrs.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Hyaline membrane

DUE TO

9 hrs

(C)

prematurity - 20 wks gestation

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 7-8-53, 19 to 7-8-53, 19, that I last saw the deceased alive on 7-8-1953 and that death occurred at 11 P. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

James M. Fair

M. D.

400 N. Carrollton Ave

7-9-53

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

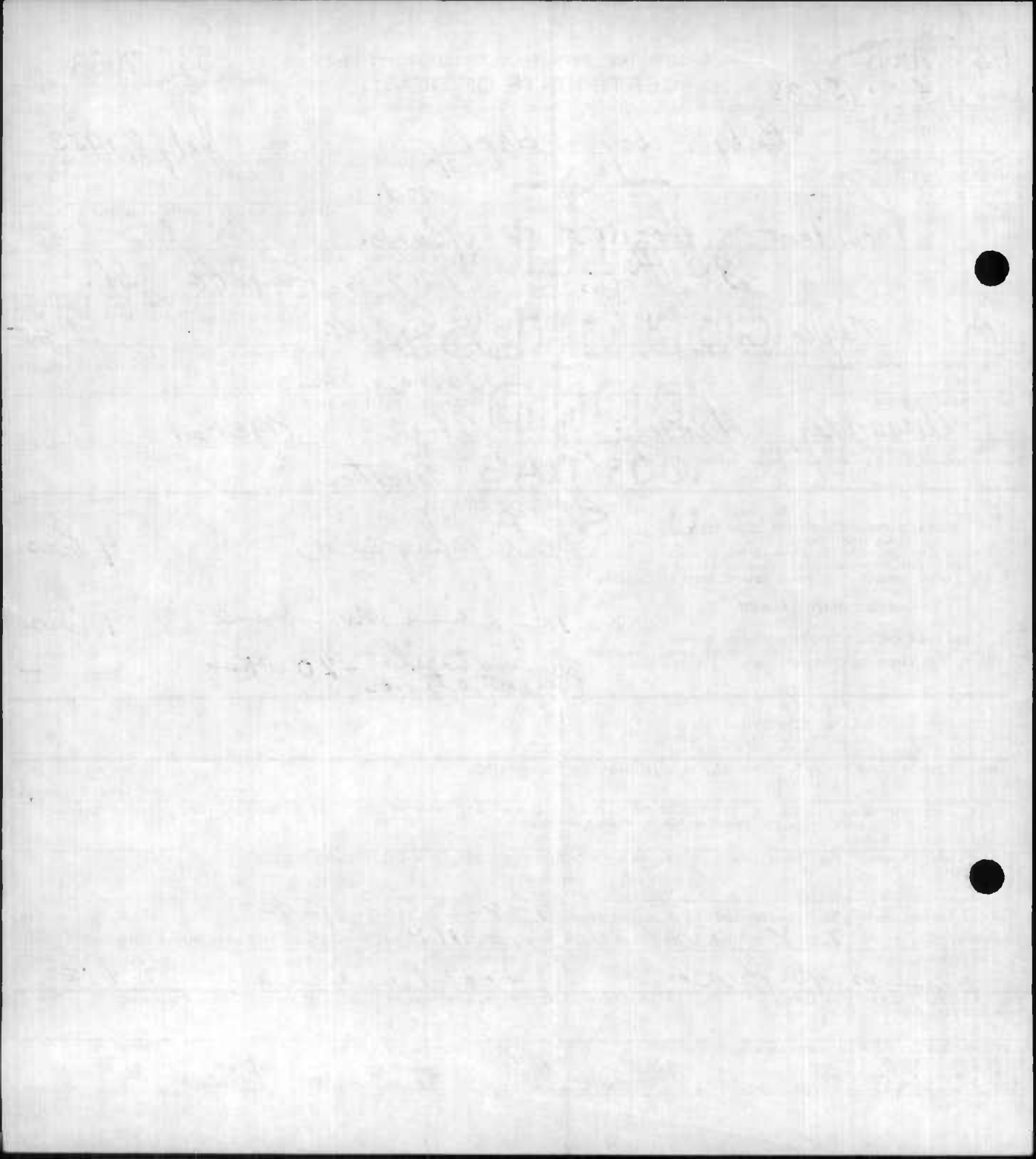
25. FUNERAL DIRECTOR

ADDRESS

AUG 5 1953

Huntington, W. Va.

Huntington, W. Va.



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7069  
Registered No.53 7069  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM ORVILLE STOCKSDALE</b>			2. DATE OF DEATH <b>August 3, 1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF (not in hospital or institution, give street address or location) <b>Maryland General Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore <b>Life</b> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>1913 Park Avenue</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>July 5, 1905</b>	9. AGE (in years last birthday) <b>48</b>	If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Auto Sales and Service</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>William Tilden Stocksdale</b>			14. MOTHER'S MAIDEN NAME <b>Mattie Cryder Belt</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-01-4040</b>	17. INFORMANT ADDRESS <b>Mrs. Isabel S. Hoffacker 533 Overbrook Rd.</b>		

18. **E 983x**

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) **Subdural Hemorrhage**  
DUE TO

## ANTECEDENT CAUSES

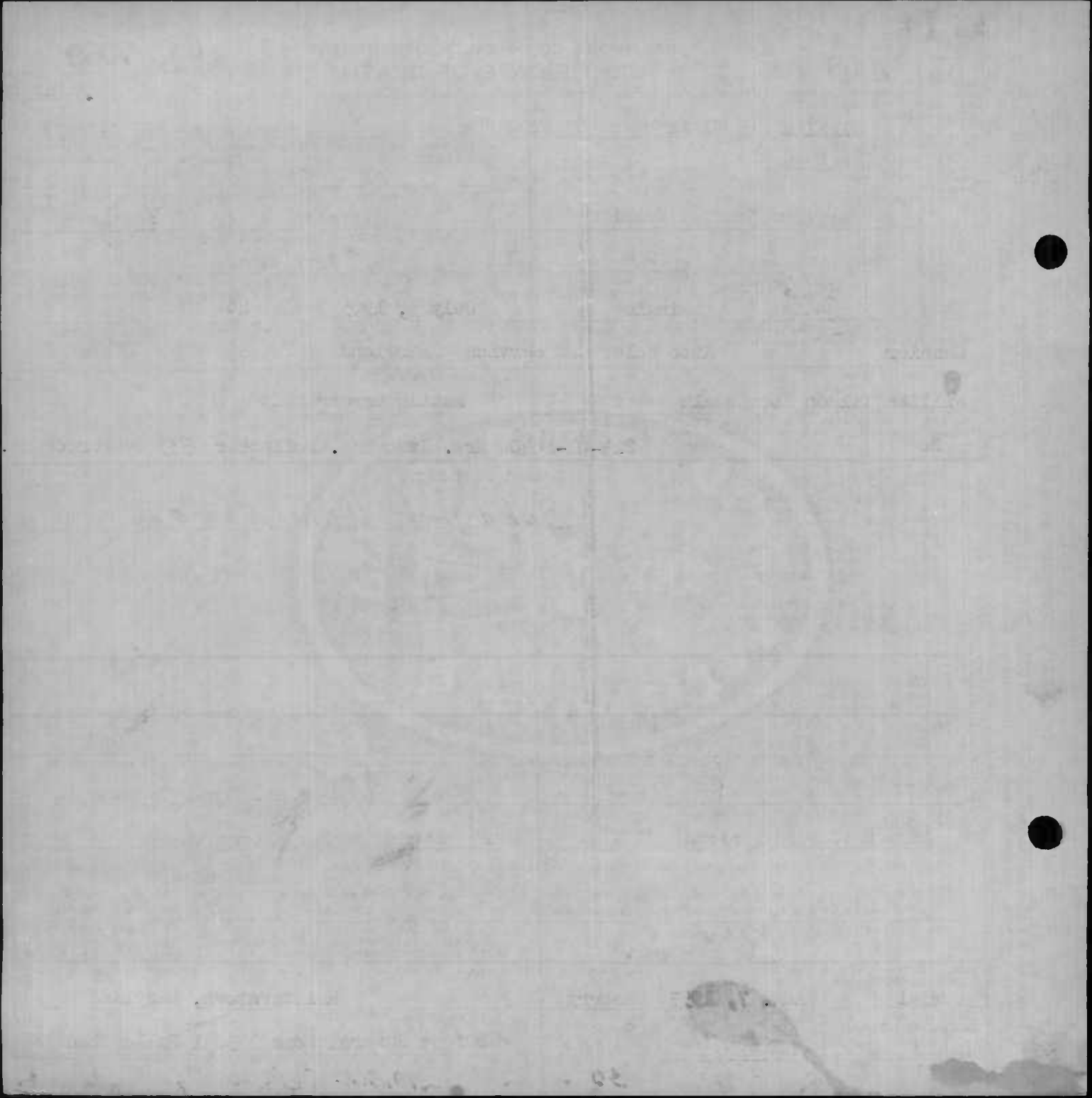
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)   
DUE TO  
(C)   
II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>2000 block of Mt. Royal Terrace</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>August 3, 1953 12:30 A.M.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Struck during altercation</b>	
22. I certify that I took charge of the remains described above, held an <b>Autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>R. Fisher</b>		23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>August 3, 1953</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Aug. 7, 1953</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Asbury</b>	24D. LOCATION (City, town, or county) (State) <b>Reisterstown, Maryland</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 5 1953</b>	REGISTRAR'S SIGNATURE <b>Huntington</b>	25. FUNERAL DIRECTOR <b>Burgee Funeral Home 3631 Falls Road</b>	
VS 151 <b>N 854.2</b> <b>320 6J</b> <b>Horace F. Burgee</b>			



D-260

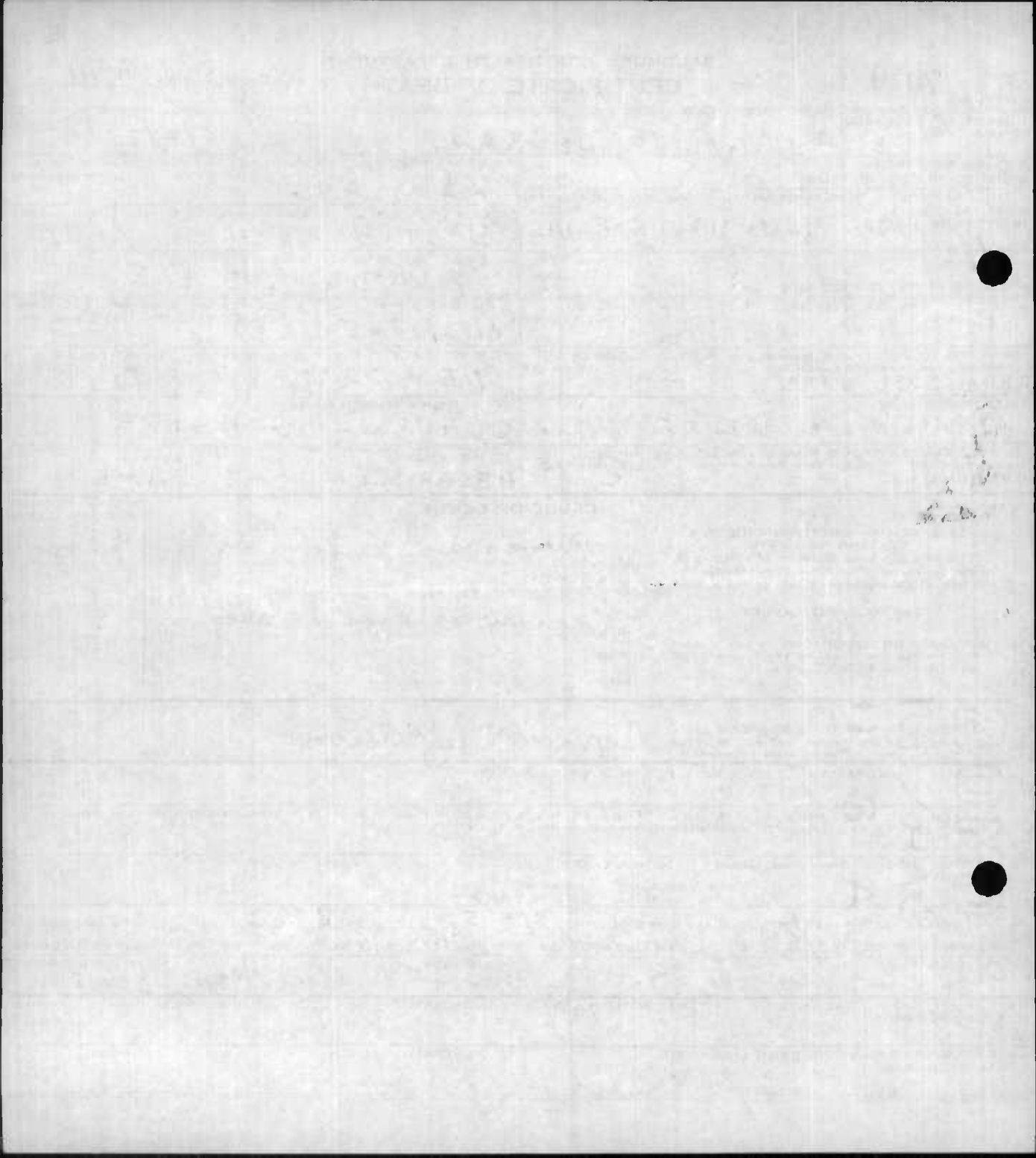
53 7070

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7070

1. NAME OF DECEASED (Type or Print) <b>DELLA CAROLINE DE GRAW</b>			2. DATE OF DEATH <b>8/4/53</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>-</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE-12 27-12</b>		
c. Length of stay in Baltimore <b>?</b> Yrs. <b>?</b> Mos. <b>?</b> Days <b>?</b>			D. STREET ADDRESS (If rural, give location) <b>318 WOODBOURNE AVE.</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>S</b>	8. DATE OF BIRTH <b>8/13/1865</b>	9. AGE (In years last birthday) <b>87</b>	If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REGISTERED NURSE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>
13. FATHER'S NAME <b>ANDREW W. DE GRAW</b>			14. MOTHER'S MAIDEN NAME <b>CLARISSA SCHAPPE</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>?</b>	17. INFORMANT ADDRESS <b>HELEN S. FISK SAME</b>		
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Myocardial infarction</b> DUE TO (B) <b>Coronary arteriosclerosis</b> DUE TO (C) <b>?</b>			INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>?</b>		
19. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Auricular fibrillation</b>			<b>?</b>		
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>8/3/53</b> , 19 <b>53</b> , to <b>8/4/53</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>8/4/53</b> , 19 <b>53</b> , and that death occurred at <b>7:11 A</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>Henry S. Adcock, Jr.</b>		23B. ADDRESS <b>Union Memorial Hosp.</b>		23C. DATE SIGNED <b>8/4/53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>Aug 5 1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Hornell New York</b>	
24D. LOCATION (City, town, or county) (State) <b>4905 York Rd</b>		24E. DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 5 1953</b>		24F. REGISTRAR'S SIGNATURE <b>Huntington</b>	
24G. FUNERAL DIRECTOR <b>740 Kind</b>		24H. ADDRESS <b>4905 York Rd</b>			

MEDICAL CERTIFICATION





W-362  
53 7071  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

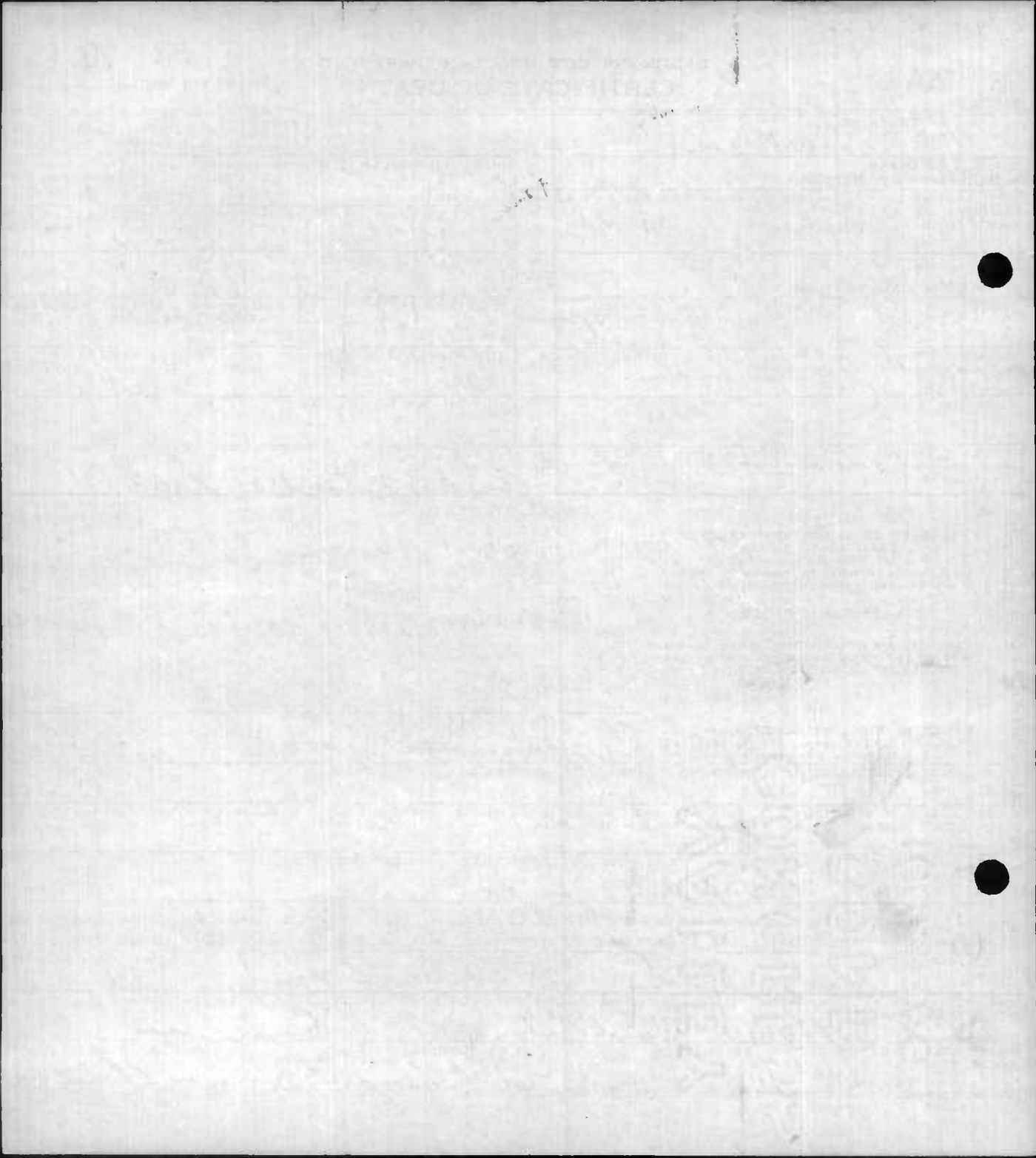
53 7071  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Louise M Waters</i>		2. DATE OF DEATH <i>3 Aug 53</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland ✓		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Lutheran Hosp. of Md.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 27-19</i>	
C. Length of stay in Baltimore <i>46</i> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>2505 Crest Rd.</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>6/21/91</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>	9. AGE (In years last birthday) <i>62</i>
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>-</i>		14. MOTHER'S MAIDEN NAME <i>-</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>✓</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Frank B. Waters</i>		ADDRESS <i>2505 Crest Rd.</i>	

18. <i>331X and 170X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>right</i> <i>Carcinoma breast</i>	CAUSE OF DEATH (A) <i>Cerebral Hemorrhage</i> DUE TO (B) <i>Essential Hypertension</i> DUE TO (C) <i>-</i>	INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs.</i> <i>3 years +</i> <i>18 mos.</i>
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19A. DATE OF OPERATION <i>- 0</i>		19B. MAJOR FINDINGS OF OPERATION <i>-</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <i>-</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>-</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>-</i>	
21D. TIME (Month) (Day) (Year) (Hour) INJURY <i>-</i>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>-</i>	
22. I hereby certify that I attended the deceased from <i>3 Aug, 1953</i> , to <i>3 Aug, 1953</i> that I last saw the deceased alive on <i>3 Aug, 1953</i> , and that death occurred at <i>10:08</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Glennard E. Burk</i>		23B. ADDRESS <i>Lutheran Hospital</i>		23C. DATE SIGNED <i>3 Aug 53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/7/53</i>		24C. NAME OF CEMETERY OR CREMATORY <i>David Ridge</i>	
24D. LOCATION (City, town, or county) (State) <i>Pikesville Md.</i>		25. FUNERAL DIRECTOR <i>Huntington Williams</i>			
DATE RECEIVED BY LOCAL REGISTRAR <i>UG 5 1953</i>		ADDRESS <i>3651 Chestnut Ave</i>			

MEDICAL CERTIFICATION



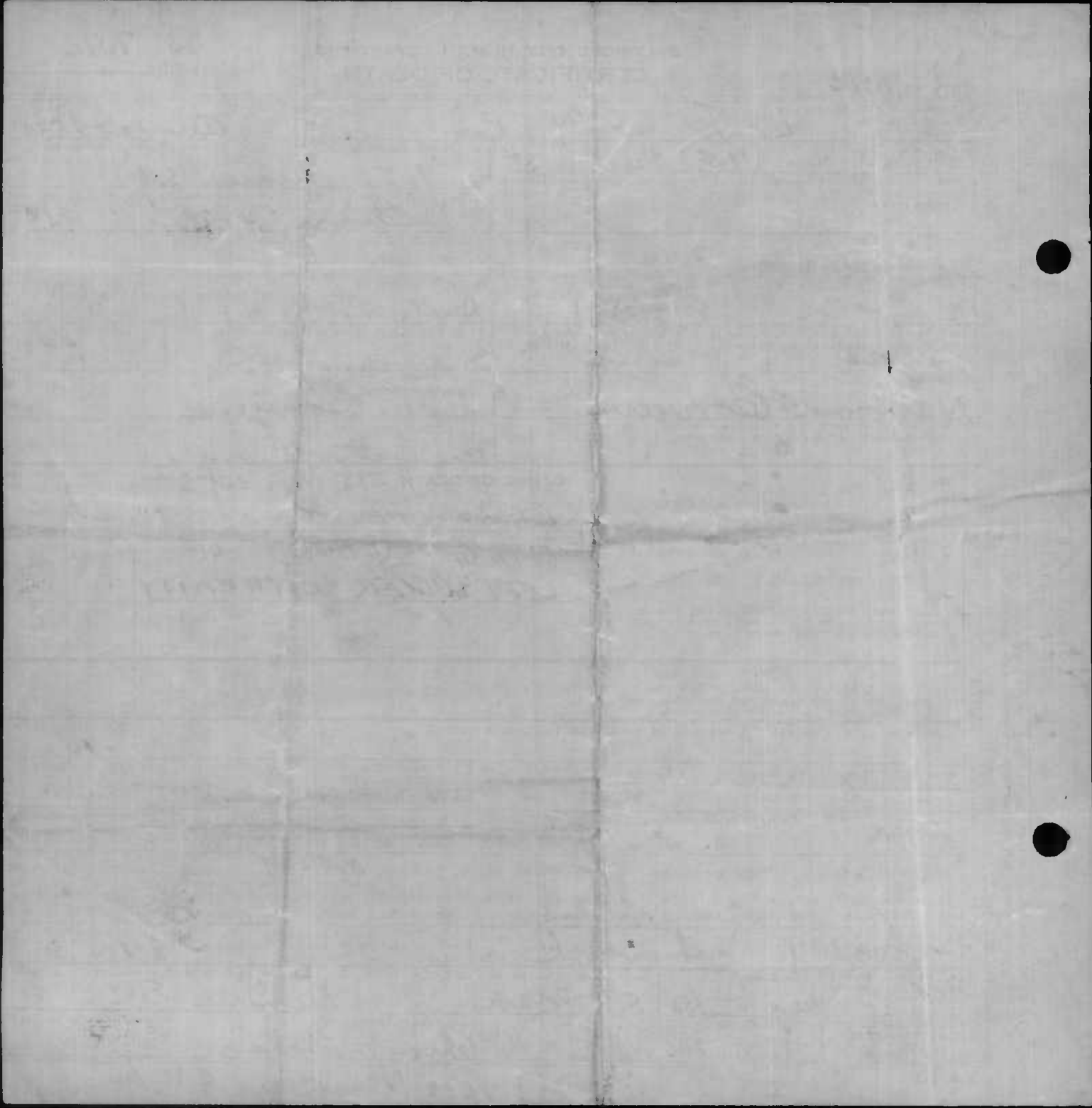
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7072  
Registered No.

BIRTH NO. 53 7072

1. NAME OF DECEASED (Type or Print) <b>L. J. CONYERS</b>			2. DATE OF DEATH <b>Aug 1st/53</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>1152 Russell St</b>			4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE <b>1152 Russell St</b> B. COUNTY <b>MD</b> C. CITY OR TOWN <b>Baltimore</b> (If outside corporate limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) <b>M 21-01</b>		
5. SEX <b>M</b>			6. COLOR OR RACE <b>Cole</b>		
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>			8. DATE OF BIRTH <b>Sept. 12th</b>		
9. AGE (in years last birthday) <b>41</b>			10. BIRTHPLACE (State or foreign country) <b>SC</b>		
11. BIRTHPLACE (State or foreign country) <b>SC</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Harmond Conyers</b>			14. MOTHER'S MAIDEN NAME <b>Dore Conyers</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Mrs Ester Dingle</b>			ADDRESS		

18. <b>E 981X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>EXSANGUINATION DUE TO GUNSHOT WOUND OF LEFT LOWER EXTREMITY</b>		INTERVAL BETWEEN ONSET AND DEATH
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>1100 block Denver St. (near West St.)</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>8/1/53</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Shot during altercation</b>	
22. I certify that I took charge of the remains described above, held an <b>Autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>Joseph J. Jachimczyk</b>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. <b>8-1-53</b>		23C. DATE SIGNED	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Aug 6th/53</b>		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <b>St. Marks</b>	
24D. LOCATION (City, town, or county) (State) <b>Dillins SC.</b>		24E. LOCATION (City, town, or county) (State)		24F. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 5 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>Choy O Wilson</b>	
VS 151		N 895.4		97095 1000 Brantley A.V. Baltimore	



A-254

V.S. 153

McNALLY

53 7073

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) <i>Charles McNally</i>		2. DATE OF DEATH <i>8/4/53</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hosp. Inc</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 27-11</i>	
C. Length of stay in Baltimore <i>418 Life</i>		D. STREET ADDRESS (If rural, give location) <i>4620 York Rd.</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>Wh.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>DIVORCED</i>	8. DATE OF BIRTH <i>8</i>
9. AGE (In years last birthday) <i>48</i>		10. Under 1 Year Months: Days: Hours: Min.	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CHAUFFEUR</i>		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	
18. <i>581.0</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>HEPATIC COMA</i> DUE TO ANTECEDENT CAUSES <i>Cirrhosis of Liver</i> DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>8/8/53</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>6/27/53</i> , 19__, to <i>8/4/53</i> , 19__, that I last saw the deceased alive on <i>8/4/53</i> , 19__, and that death occurred at <i>11:10 AM</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>E. P. Goff</i>		23B. ADDRESS <i>Mercy Hosp.</i>	
23C. DATE SIGNED <i>8/8/53</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>8/8/53</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>New Eastern</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>UG 5 1953</i>		REGISTRAR'S SIGNATURE <i>Funerary William, MD</i>	
25. FUNERAL DIRECTOR <i>68352</i>		ADDRESS <i>2 Ruck</i>	

MEDICAL CERTIFICATION

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1911

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

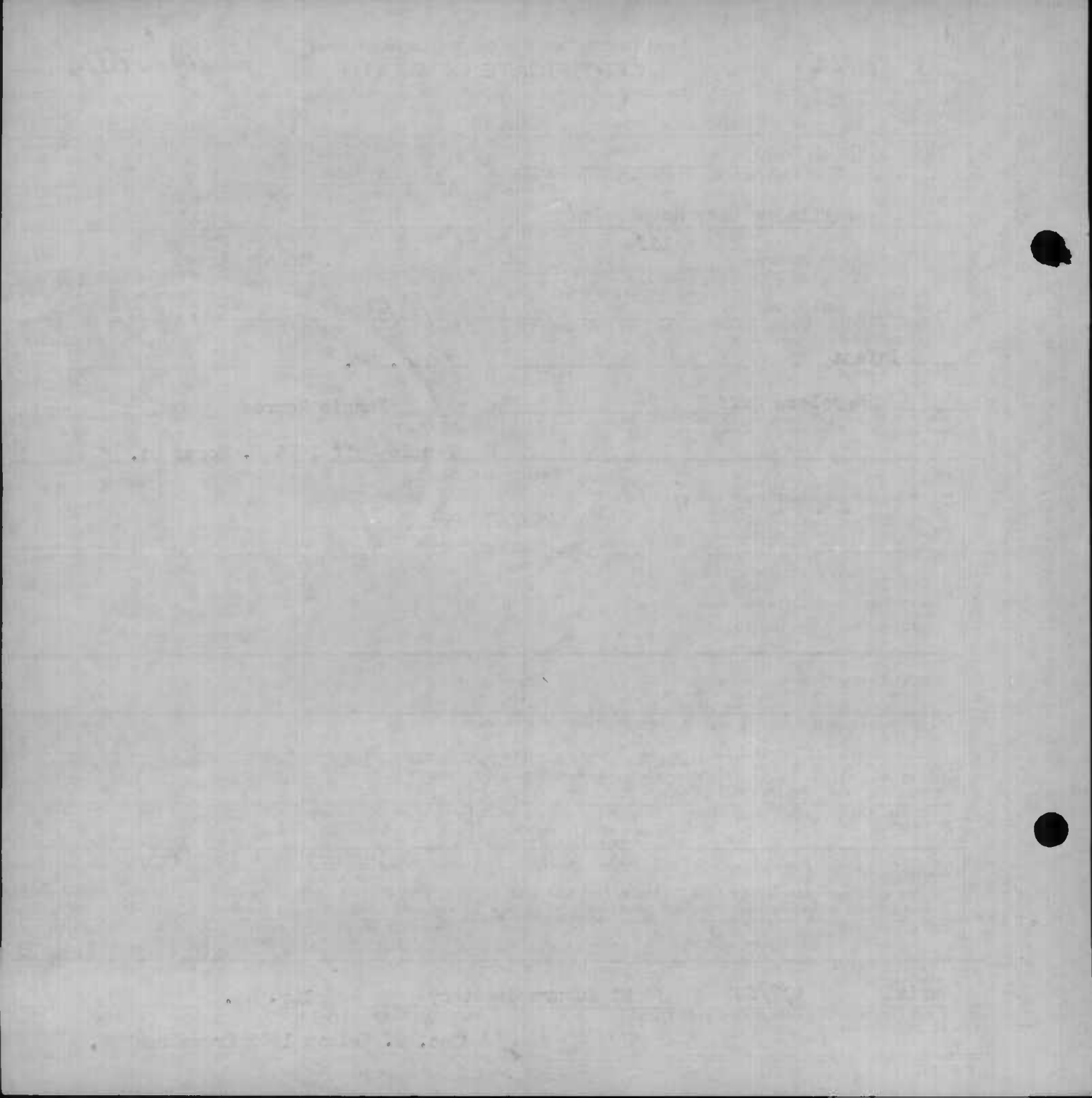
FOR THE YEAR 1910

ALBANY: J.B. LEECH, STATE PRINTER



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 53-7074	
BIRTH NO. 53-7074-06769				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>NAPOLIAN MONROE</b>			2. DATE OF DEATH <b>August 2, 1953</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>1426 N. Mount Street</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>3/23/53</b>	9. AGE (In years last birthday) <b>4</b>	If Under 1 Year Months Days If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Napoleon Duff</b>			14. MOTHER'S MAIDEN NAME <b>Fannie Monroe</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Fannie Duff 1426 N. Mount St.</b>		
18. <b>571.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Dehydration</b> DUE TO <b>diarrhea</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <b>Inspection &amp; Inquiry</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <b>natural causes</b> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>R. F. Fisher</b>		23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>August 3, 1953</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8/7/53</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>1553</b>	REGISTRAR'S SIGNATURE <b>W. Williams</b>	25. FUNERAL DIRECTOR <b>Geo. G. Kelson</b>		ADDRESS <b>1303 Presstman St.</b>	
V S 151 <b>1553</b>					



J-460  
53 7075

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7075

BIRTH NO.			1. NAME OF DECEASED (Type or Print) <b>MR. SAMUEL Tillery</b>			2. DATE OF DEATH <b>8/3/53</b>									
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Balto. City</b>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>												
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>77 Mercy Hosp. Inc</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>												
C. Length of stay in Baltimore <b>40</b>			D. STREET ADDRESS (If rural, give location) <b>2453 Woodbrook Ave #12</b>												
5. SEX <b>M</b>		6. COLOR OR RACE <b>Colored</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>11-1-05</b>		9. AGE (In years last birthday) <b>47</b>		If Under 1 Year Months: Days		If Under 24 Hours Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>				11. BIRTHPLACE (State or foreign country) <b>N. Carolina</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Nelious Tillery</b>						14. MOTHER'S MAIDEN NAME <b>May Hunter</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>unknown</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>daughter</b> <b>Mrs. Carrie Evans</b>						ADDRESS <b>(as above)</b>			
18. <b>581.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Hepatic Coma</b> DUE TO <b>(A)</b> <b>Cirrhosis of the liver</b> DUE TO <b>(B)</b> <b>(C)</b>						CAUSE OF DEATH <b>3 days</b> <b>? 10 yrs +</b>									
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.															
19A. DATE OF OPERATION <b>7</b>			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME (Month) (Day) (Year) (Hour) INJURY			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?									
22. I hereby certify that I attended the deceased from <b>6/2</b> , 1953, to <b>8/3</b> , 1953, that I last saw the deceased alive on <b>8/3</b> , 1953, and that death occurred at <b>9:35A.m.</b> , from the causes and on the date stated above.															
23A. SIGNATURE <b>Dawson</b>						23B. ADDRESS <b>Mary Hays</b>			23C. DATE SIGNED <b>8/3/53</b>						
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>8/6/1953</b>			24C. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary Cem.</b>			24D. LOCATION (City, town, or county) (State) <b>Brooklyn Md.</b>						
DATE RECEIVED BY LOCAL REGISTRAR <b>ICE 1953</b>			REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>			25. FUNERAL DIRECTOR <b>E. O. Wilson</b>			ADDRESS <b>1000 Brantly</b>						

# CERTIFICATE OF DEATH

IN THE CITY AND COUNTY OF DENVER

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CERTIFICATE OF DEATH

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BIRTH NO.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Reinhardt, Bessie Katherine		August 4, 1953	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 3814 Greenmount Avenue	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Feb. 11, 1893
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Frank Habercam		14. MOTHER'S MAIDEN NAME Rose A. Cunningham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mary V. Reinhardt-3814 Greenmount Ave		ADDRESS	
18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Thrombosis of the brain DUE TO Arteriosclerotic cardiovascular disease DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 7		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 19, 1953 to August 4, 1953 that I last saw the deceased alive on August 4, 1953, and that death occurred at 2:10 a. m., from the causes and on the date stated above.			
23A. SIGNATURE Nathaniel O. Santiago		23B. ADDRESS 1100 N. Caroline Street	
23C. DATE SIGNED August 4, 1953			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 7, 1953	
24C. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE Huntington Williams, M.D.	
25. FUNERAL DIRECTOR John A. Moran		ADDRESS 3000 E. Baltimore St.	

RECEIVED  
CITY OF NEW YORK  
DEPT. OF HEALTH

NEW YORK  
JAN 10 1910

TO THE  
HONORABLE  
THE BOARD OF HEALTH  
CITY OF NEW YORK  
FROM  
THE  
COMMISSIONER OF HEALTH  
CITY OF NEW YORK  
SUBJECT  
REPORT  
ON THE  
MORBIDITY AND MORTALITY  
IN THE CITY OF NEW YORK  
DURING THE YEAR 1909  
BY  
JOHN W. H. WARD  
COMMISSIONER OF HEALTH  
CITY OF NEW YORK  
1910



W-426  
53 7077BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7077

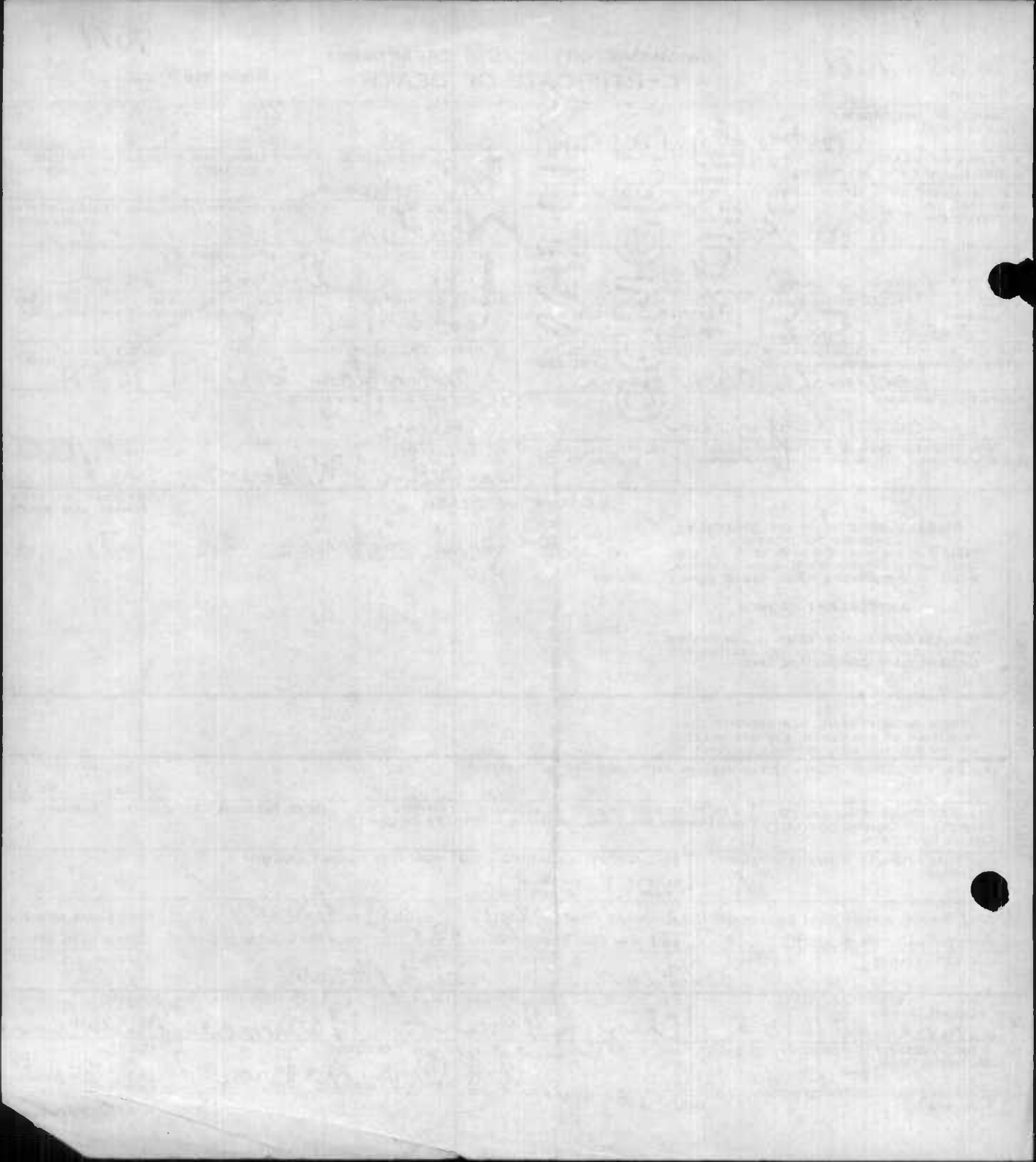
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Betty F. Wilder</i>		2. DATE OF DEATH <i>8/4/53</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hosp.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 17-20</i>	
Length of stay in Baltimore <i>24 yrs.</i>		O. STREET ADDRESS (If rural, give location) <i>3412 Shelburne Road</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLY MARRIED <i>WIDOWED, DIVORCED</i> <i>married</i>	8. DATE OF BIRTH <i>Nov 5, 1921</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>St. Jesse Flegman</i>		14. MOTHER'S MAIDEN NAME <i>Evelyn</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Dr. Milton J. Wilder</i>	
18. <i>201X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Hodgkin's Disease</i>		ADDRESS <i>Road 3412 Shelburne</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		INTERVAL BETWEEN ONSET AND DEATH <i>7 1/2 yrs</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>July 1</i> , 19 <i>53</i> to <i>August 4</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>Aug 4</i> , 19 <i>53</i> , and that death occurred at <i>4:50</i> p. m., from the causes and on the date stated above.			
23A. SIGNATURE <i>Daniel Bakalao</i>		23B. ADDRESS <i>Buick Hosp.</i>	
23C. DATE SIGNED <i>8/4/53</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/6/53</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Chizuk Amuno</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>Huntington Williams, M.D.</i>		REGISTRAR'S SIGNATURE <i>Sol. Levinson</i>	
25. FUNERAL DIRECTOR <i>Broz</i>		ADDRESS <i>1124-26 W. North Ave.</i>	

MEDICAL CERTIFICATION

UG 5 VS 1353



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAF- 172396

53

7078

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53

7078

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Albert Crowley

2. DATE  
OF

DEATH Aug. 4, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

Baltimore City Hospitals

4940 Eastern Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore

24-03

D. STREET ADDRESS (If rural, give location)

1119 Light St. zone #30

c. Length of stay in Baltimore

life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Wid.

8. DATE OF BIRTH

May 4, 1885

9. AGE (In years  
last birthday)

68

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Frederick Crowley

14. MOTHER'S MAIDEN NAME

Mary Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

B. C. H. 4940 Eastern Ave. (records)

18. 002X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Lobar Pneumonia

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Tuberculous Enteritis Large bowel

DUE TO

(C) Pulmonary Tuberculosis

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

7-24-53

19B. CONDITION FOR WHICH OPERATION

Blount plate - left hip

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-17, 1953, to 8-4, 1953 that I last saw the  
deceased alive on 8-4, 1953, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

H. J. John Doe, M.D.

23B. ADDRESS

4940 Eastern Ave., Balto., Md.

23C. DATE SIGNED

8-4-1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8/7/1953

24C. NAME OF CEMETERY OR CREMATORY

Cathedral

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

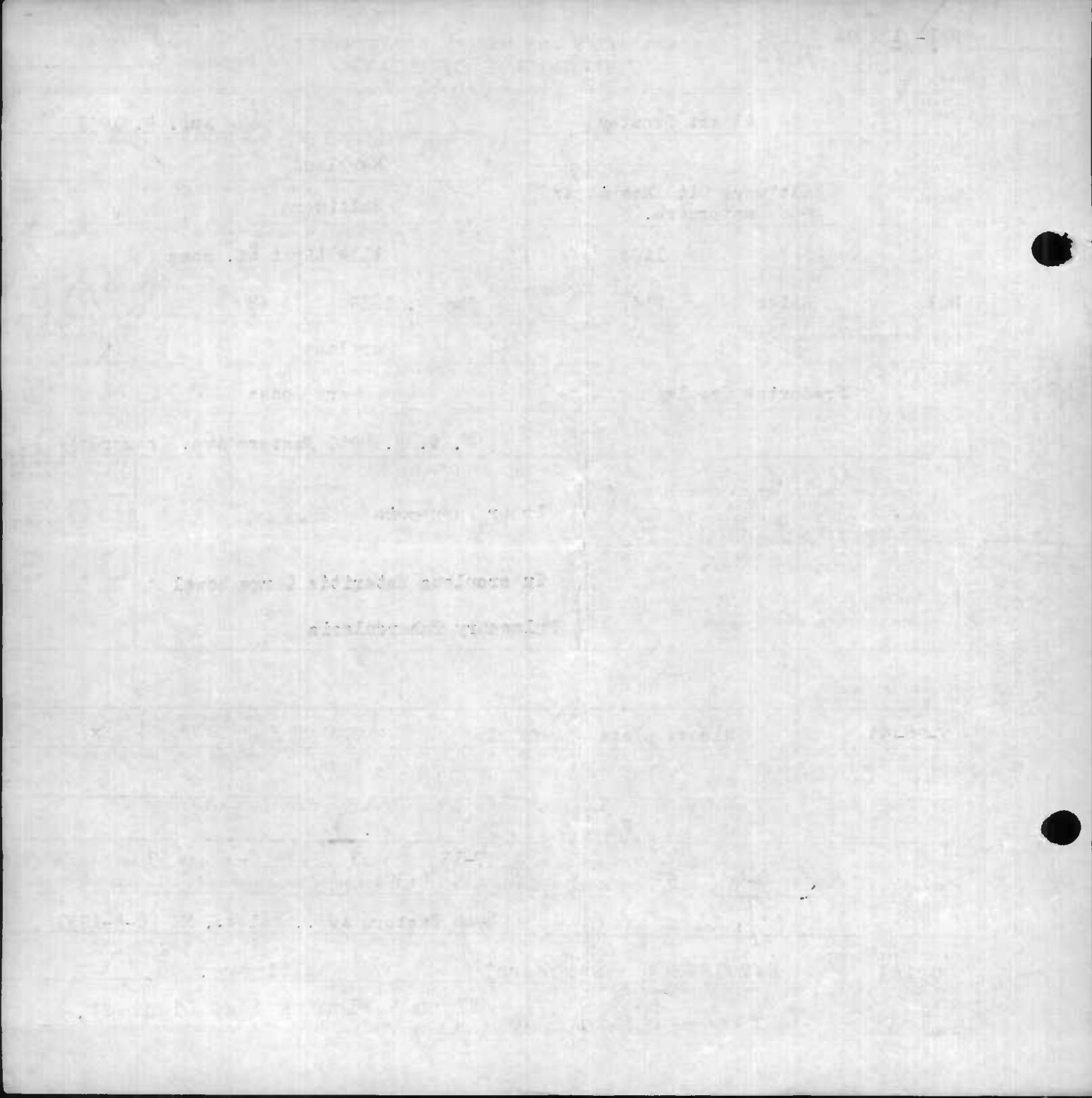
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Flynn &amp; Fleming 1426 Light St.

ADDRESS



MARGINAL INFORMATION		CERTIFICATE AMENDED 8/24/53 ES		BALTIMORE CITY HEALTH DEPARTMENT		53 7079	
DATE-172925 H-230		BIRTH NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <b>John Height</b>				2. DATE OF DEATH <b>Aug. 1, 1953</b>			
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>			
c. Length of stay in Baltimore <b>life</b>				D. STREET ADDRESS (If rural, give location) <b>101 S. Spring St.</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>July 3, 1872</b>	9. AGE (In years last birthday) <b>81</b>	10. Under 1 Year Months: Days	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Height</b>				14. MOTHER'S MAIDEN NAME <b>Mary Wheeler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>B. C. H. 4940 Eastern Ave. (records)</b>			
18. <b>161 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Terminal Pneumonia</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Metastatic Carcinoma</b> DUE TO <b>Larynx - ?</b>				CAUSE OF DEATH <b>CLIFFORD HEIGHT 101 S. SPRING ST.</b> INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>7-31</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <b>7-31</b> , 19 <b>53</b> , to <b>8-1</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>8-1</b> , 19 <b>53</b> , and that death occurred at <b>4:55A</b> m., from the causes and on the date stated above.							
23A. SIGNATURE <b>H. J. ...</b>				23B. ADDRESS <b>4940 Eastern Ave., Balto., Md.</b>		23C. DATE SIGNED <b>8-1-1953</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <b>8-4-53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MT. CALVERY</b>		24D. LOCATION (City, town, or county) (State) <b>BROOKLING.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>5 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		25. FUNERAL DIRECTOR'S ADDRESS <b>C. O. Wilson, 1000 Boartry. AVE.</b>			

See query reply in Document File



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

P-620  
53 7080

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

X 53 7080  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Robert Pierce*

2. DATE  
OF  
DEATH

*August 4, 1953*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

*Brady*

4. USUAL RESIDENCE (Where deceased lived, before admission):  
A. STATE B. COUNTY

*md*

*Harford*

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

*JOHNS HOPKINS HOSPITAL*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Street*

D. STREET ADDRESS (If rural, give location)

*6200*

c. Length of stay in Baltimore

*2*

5. SEX

*male*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*married*

8. DATE OF BIRTH

*12-9-165*

9. AGE (In years last birthday)

*87*

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*BLACKsmith*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Ash Co. N.C.*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*Andrew Jackson Pierce*

14. MOTHER'S MAIDEN NAME

*JANE Scott*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*JOHNS HOPKINS HOSPITAL*

18. *177X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

*Myocardial Infarction & Shock*

INTERVAL BETWEEN ONSET AND DEATH

*24 hrs.*

ANTECEDENT CAUSES

DUE TO

(B)

*Lung abscess, arteriosclerosis*

DUE TO

(C)

*Carcinoma of prostate, uremia 8 yrs.*

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

*12/10/45, 6/19/53*

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

*Ca of Prostate*

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office hldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *8-4, 1953*, to *8-4, 1953*, that I last saw the deceased alive on *8-4, 1953*, and that death occurred at *11:05 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*William Bauman*

23B. PLACE

*JOHNS HOPKINS HOSPITAL*

23C. DATE SIGNED

*8/5/53*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*BURIAL*

24B. DATE

*Aug. 7, 1953*

24C. NAME OF CEMETERY OR CREMATORY

*BEL Air Memorial Gardens*

24D. LOCATION (City, town, or county)

*BEL-Air*

(State)

*MD*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Huntington Williams, M.D.*

25. FUNERAL DIRECTOR

*Joseph T. Foster*

ADDRESS

*BEL-air, Md.*

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

K-346

53 7081

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7081

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Kettler, Anna Katherine</b>		2. DATE OF DEATH <b>8.4.53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) INSTITUTION <b>St. Agnes Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore, Maryland</b> <b>28-04</b>	
D. STREET ADDRESS (If rural, give location) <b>5452 Frederick Avenue #29</b>			
c. Length of stay in Baltimore <b>64 Yrs</b>		Yrs. Mos. Days	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>5.14.89</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Floor Manager</b>	10B. KIND OF BUSINESS OR INDUSTRY <b>Retail Dept. Store</b>	9. AGE (In years last birthday) <b>64</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland Balto.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Gebhardt</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT ADDRESS <b>Mrs. Viola Kettler 5509 Gwynn Oak Ave.</b>	
18. <b>443X</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral vascular accident</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Hypertensive-arteriosclerotic C-V disease</b> DUE TO (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	21F. HOW DID INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22. I hereby certify that I attended the deceased from <b>8-2</b> 19 <b>53</b> , to <b>8-4</b> 19 <b>53</b> , that I last saw the deceased alive on <b>8-4</b> 19 <b>53</b> , and that death occurred at <b>4:45 P.M.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Donald A. Wolfel</b> M.D.		23B. ADDRESS <b>St Agnes Hospital</b>	23C. DATE SIGNED <b>8-4-53</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8/7/53</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <b>Huntington Hill, Md.</b>	25. FUNERAL DIRECTOR <b>Wm. J. Eckner's Son Inc. Balto Md</b>	ADDRESS

AUG 6 1953

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WALLEY  
CONGRESS

BOND

DOORWAY

11.11

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7082

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53

7082

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Margaret Rose

2. DATE  
OF  
DEATH

Aug. 5, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

A 30 N

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR

INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

15-04

D. STREET ADDRESS (If rural, give location)

1840 W. North Ave

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

3-30-1887

9. AGE (In years last birthday)

66

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Home

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Aaron Rubin

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

JOHNS HOPKINS HOSPITAL

18. 443X and 260X

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Cardiac Decompensation

DUE TO

(B) Chronic Hypertensive Heart Disease

DUE TO

(C) Persistent Paralytic Ileus post Nephrectomy  
Diabetes Mellitus.INTERVAL BETWEEN  
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH. ENTER IN  
PART I OR PART II20. AUTOPSY?  
YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/6 1953 to 8/5 1953, that I last saw the deceased alive on 8/5 1953 and that death occurred at 4:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE

R. J. McNeill

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

8-5-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Cremation

24B. DATE

8/5/53

24C. NAME OF CEMETERY OR CREMATORY

Loudon Pk Crematory

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 5 1953

Huntington Williams &amp; Son Inc Baltimore Md



James H. Thompson

James H. Thompson

James H. Thompson

James H. Thompson

James H. Thompson

James H. Thompson



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

53 7083

53 7083  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

RO1 CLAYVILLE BREWINGTON

2. DATE  
OF  
DEATH

Aug. 5, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Worcester

B. FULL NAME OF (If not in hospital or institution, give street address or hospital or institution location)

US Public Health Service Hospital  
Wyman Pk. Drive & 31st Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Snow Hill

D. STREET ADDRESS (If rural, give location)

PO Box 122

5. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

8/18/91

9. AGE (In years last birthday)

61

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Captain

10B. KIND OF BUSINESS OR INDUSTRY

Seafarer

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Edward Alvin Brewington

14. MOTHER'S MAIDEN NAME

Georgia Clayville

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.  
216-11-2828

17. INFORMANT

Records- US PHS Hospital, Balto, Md.

ADDRESS

18.

163x

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia, secondary to

Recent

DUE TO

ANTECEDENT CAUSES

(B) Pulmonary congestion, secondary to

Recent

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) carcinoma of the lung, bilateral

Several months

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 9, 1953, to Aug. 5, 1953, that I last saw the deceased alive on Aug. 5, 1953 and that death occurred at 9:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE

J. A. Hunter  
Clinical Director

23B. ADDRESS

US PHS Hospital, Balto, Md.

23C. DATE SIGNED

8/5/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

Aug 9/53

24C. NAME OF CEMETERY OR CREMATORY

Methodist

24D. LOCATION (City, town, or county)

Snow Hill, Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 6 1953

REGISTRAR'S SIGNATURE

Huntington

25. GENERAL DIRECTOR

William H. Dennis

ADDRESS

Snow Hill, Md

VS 150

24055

CLAY E. DENNIS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-655		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 53 7084	
FWJ 122356		CERTIFICATE OF DEATH			
BIRTH NO. 53 7084		1. NAME OF DECEASED (Type or Print) <b>Solomon Berman</b>		2. DATE OF DEATH <b>7-17-1953</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>18-03</b>			
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>			
c. Length of stay in Baltimore <b>?</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>22 South Carlton St.</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>?</b>	8. DATE OF BIRTH <b>???</b>	9. AGE (In years last birthday) <b>55?</b>	10. Under 1 Year Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>?</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>B.C.H. 4940 Eastern Ave. (record)</b>	
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>7-17-1953</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7-17-</b> , 1953, to <b>7-17-</b> , 1953 that I last saw the deceased alive on <b>7-17-</b> , 1953 and that death occurred at <b>9:50 A.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>H. J. Williams</b> M. D.		23B. ADDRESS <b>4940 Eastern Avenue</b>		23C. DATE SIGNED <b>7-17-1953</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
24D. LOCATION (City, town, or county)		(State)			
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 6 - 1953</b>		REGISTRAR'S SIGNATURE <b>H. J. Williams</b>		25. FUNERAL DIRECTOR ADDRESS <b>7 0 0 5</b>	

Source: [illegible]

H-200		CERTIFICATE AMENDED 8/24/53 ES		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 53 7085	
BIRTH NO. 53 7085		1. NAME OF DECEASED (Type or Print) <b>WILLIE A. HESS</b>				2. DATE OF DEATH <b>8/3/53</b>			
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>md.</b> B. COUNTY							
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>University Hosp</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balti.</b>				D. STREET ADDRESS (If rural, give location) <b>1505 W. Pratt St.</b>			
c. Length of stay in Baltimore <b>9</b> Yrs. <del>MOS.</del> Days		5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <b>1-1-88</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>piece</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>clothing mfg.</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Michael Garion</b>		14. MOTHER'S MAIDEN NAME <b>Sally Good</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>W8-W-0069</b>		17. INFORMANT <b>Charlotte E. Mc Dorman</b>	
18. <b>330X</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <b>Subarachnoid hemorrhage</b> <b>Generalized arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES		(A) <b>G-I bleeding</b> DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) <b>Intestinal (carcinoma-?)</b> DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Pneumonia</b>							
19A. DATE OF OPERATION <b>✓</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		21G. DATE OF INJURY		21H. DATE OF DEATH		21I. DATE OF BURIAL		21J. DATE OF CREMATION	
22. I hereby certify that I attended the deceased from <b>8/1</b> , 19 <b>53</b> , to <b>8/3</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>8/3</b> , 19 <b>53</b> , and that death occurred at <b>10:20 P.m.</b> , from the causes and on the date stated above.		23A. SIGNATURE <b>J. H. W. Wain</b>		23B. ADDRESS <b>University Hosp.</b>		23C. DATE SIGNED <b>8/4/53</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <b>8-6-53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>London Park</b>		24D. LOCATION (City, town, or county) (State) <b>Balti md</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 6 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>W. C. B. M. Wallace</b>		ADDRESS <b>690 46 Indx &amp; Truckers</b>			

See Document file for full provisional anatomical diagnosis





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7086

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HOWARD HAROLD LEPPERT

2. DATE  
OF  
DEATH

August 4, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (not in hospital or institution, give street address or location)

St. Agnes Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Woodlawn

D. STREET ADDRESS (If rural, give location)

Windsor Mill Road

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

3/5/08

9. AGE (In years  
last birthday)

45

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

LABOR

10B. KIND OF BUSINESS OR  
INDUSTRY

BALTO. CO.

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

JOHN LEPPERT

14. MOTHER'S MAIDEN NAME

ANNIE LEPPERT

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WWII

16. SOCIAL  
SECURITY NO.

17. INFORMANT

EDNA NICHOLSON

ADDRESS

18. E925.3

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Asphyxia

DUE TO Burial in sand pit

ANTECEDENT CAUSES

(B)

DUE TO

(C)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Linden Ave. &amp; Highview Ave.-Arbutus 520

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

Aug. 4, 1953 about 2:15 P. m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☒NOT WHILE  
AT WORK ☐21F. HOW DID INJURY OCCUR? Trapped in sand  
ditch while he was digging22. I certify that I took charge of the remains described above, held an autopsy thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Joseph A. Jachimek M.D.

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

August 5, 1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

8/7/53

24C. NAME OF CEMETERY OR CREMATORY

WOODLAWN

24D. LOCATION (City, town, or county)

WOODLAWN, MD.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

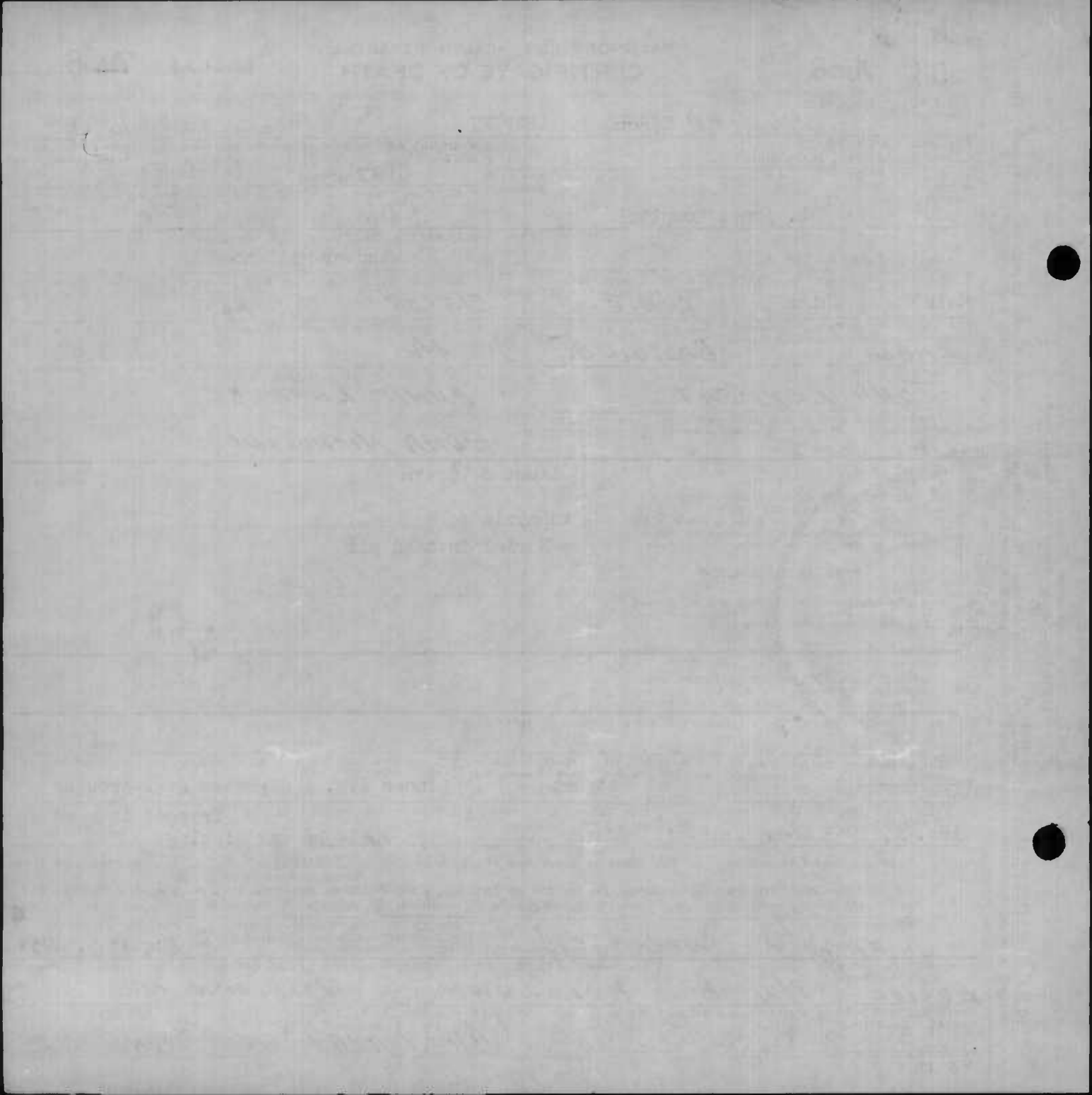
MAC NABB &amp; SON, CATONSVILLE

ADDRESS

VS 151

N 991X

97092



N-240

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7087

BIRTH NO. 53 7087

1. NAME OF DECEASED (Type or Print) Christopher John Nickol		2. DATE OF DEATH 8/4/53	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
5. FULL NAME OF HOSPITAL OR INSTITUTION 3108 Brendon Ave		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Maryland 26-03	
6. Length of stay in Baltimore 70 yrs.		D. STREET ADDRESS (If rural, give location) 3108 Brendon Ave	
5. SEX MALE Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 29, '82
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY Dietrich Bros	9. AGE (In years last birthday) 70
13. FATHER'S NAME Moritz Nickol		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Anna M. Schrenker	
17. INFORMANT Mrs. Mary C. Nickol		ADDRESS 3108 Brendon	
18. 180x DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) My Postalic Peritonitis (B) Metastatic Carcinoma (C) Primary Co. Kidney -	
19A. DATE OF OPERATION 7/0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 7-13-53 to 8-4-53, that I last saw the deceased alive on 8-1-53, 1953 and that death occurred at 4:00 p. m., from the causes and on the date stated above.			
23A. SIGNATURE Huntington Williams, M.D.	23B. ADDRESS 2707 Belair Rd.	23C. DATE SIGNED 8-2-53	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/8/53	24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
DATE RECEIVED BY LOCAL REGISTRAR AUG 6 1953	REGISTRAR'S SIGNATURE Huntington Williams, M.D.	25. FUNERAL DIRECTOR Leonard J. Ruck, 5305 Harford Rd.	

5543D

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

DALLAS COUNTY HEALTH DEPARTMENT

State of Texas

County of Dallas

City of Dallas

Deceased's Name

Age

Sex

Race

Date of Death

Place of Death

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Burial Director

Signature of Funeral Home

Signature of Cemetery

Signature of Undertaker

Signature of Embalmer

Signature of Transporter

Signature of Interment

Signature of Burial

Signature of Cremation

Signature of Disposition

Signature of Final Rest

Signature of Lasting Place

Signature of Final Destination

Signature of End of Journey

Signature of Departure

Signature of Final Farewell

L-156

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7088

53 7088

1. NAME OF DECEASED (Type or Print) <b>EVA HIPNER</b>		2. DATE OF DEATH <b>8-5-53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1122 So Charles St Baltimore 23-01</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
Length of stay in Baltimore <b>50</b> Yrs. <b>50</b> Mos. <b>50</b> Days		D. STREET ADDRESS (If rural, give location) <b>1122 So Charles St</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widow</b>	8. DATE OF BIRTH
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>72</b>
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Not known</b>		14. MOTHER'S MAIDEN NAME <b>not known</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Sam Hipner - Jane</b>		ADDRESS	
18. <b>332X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
(A) <b>Cerebral arterial thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>about 5 months</b>	
ANTECEDENT CAUSES		(B) <b>arterio-sclerosis</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) <b>hypertension</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>April 15, 1953</b> to <b>Aug 5, 1953</b> that I last saw the deceased alive on <b>Aug 5, 1953</b> and that death occurred at <b>7:15 p.m.</b> from the causes and on the date stated above.			
23A. SIGNATURE <b>Dr. Herman Seidel</b>		23B. ADDRESS <b>2404 Eutaw Pl</b>	
23C. DATE SIGNED <b>8/6/53</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8-6-53</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Loxedale</b>	24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 6 1953</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams</b>	25. FUNERAL DIRECTOR <b>James Lewis</b> ADDRESS <b>2100 Eutaw Pl</b>	

MEDICAL CERTIFICATION

Arden  
2404 East 12



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

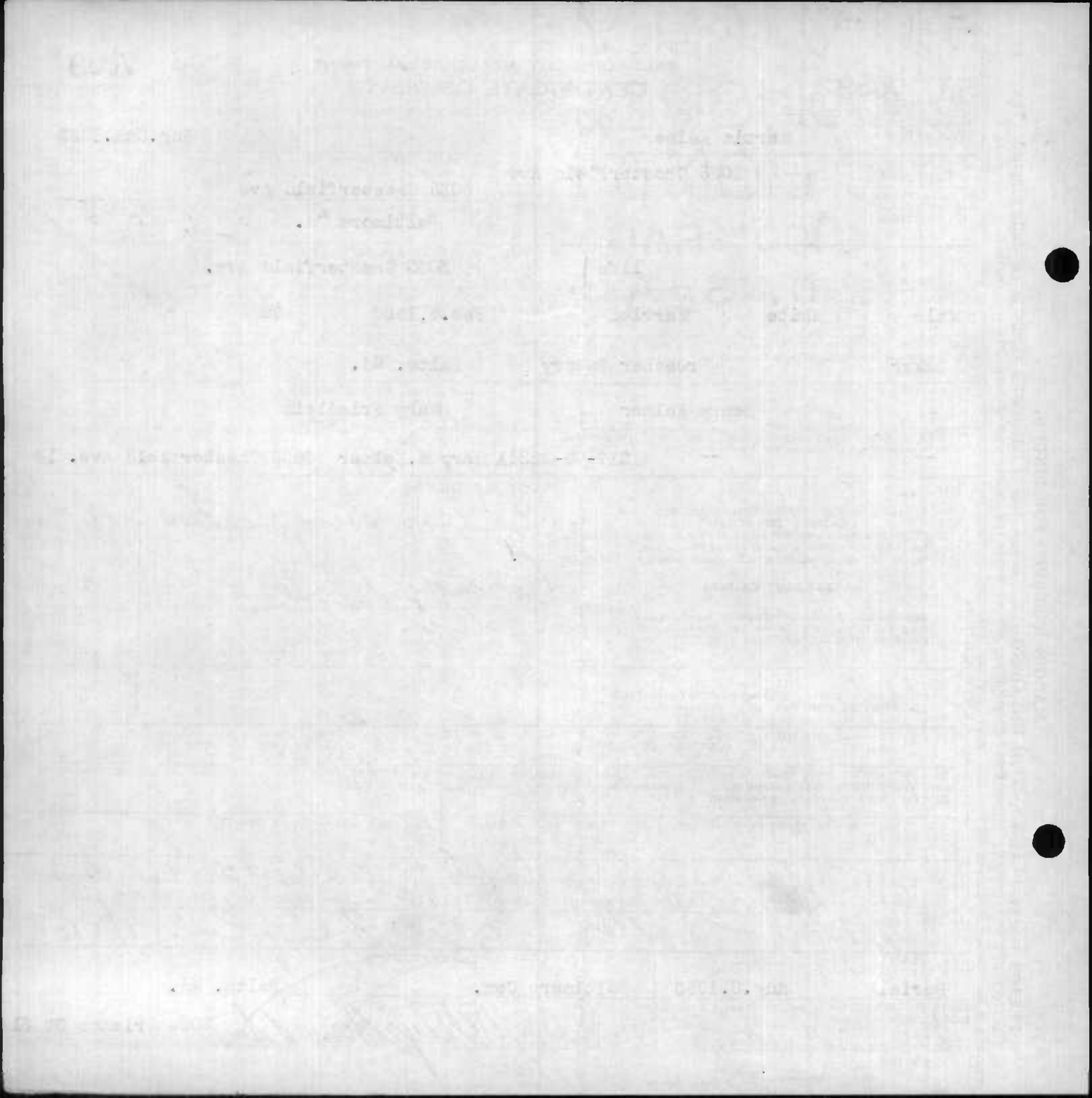
53 7089  
Registered No.

53 7089  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Martin Kelmer</b>		2. DATE OF DEATH <b>Aug. 5th. 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>3035 Chesterfield Ave</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Baltimore Md.</b> B. COUNTY <b>26-03</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
c. Length of stay in Baltimore <b>life</b>		D. STREET ADDRESS (If rural, give location) <b>3035 Chesterfield Ave.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Feb. 5, 1883</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Preacher Bakery</b>	9. AGE (in years last birthday) <b>70</b>
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry Kelmer</b>		14. MOTHER'S MAIDEN NAME <b>Mary Friedlein</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-09-2221A</b>	
17. INFORMANT <b>Mary M. Kelmer</b>		ADDRESS <b>3035 Chesterfield Ave. 13</b>	

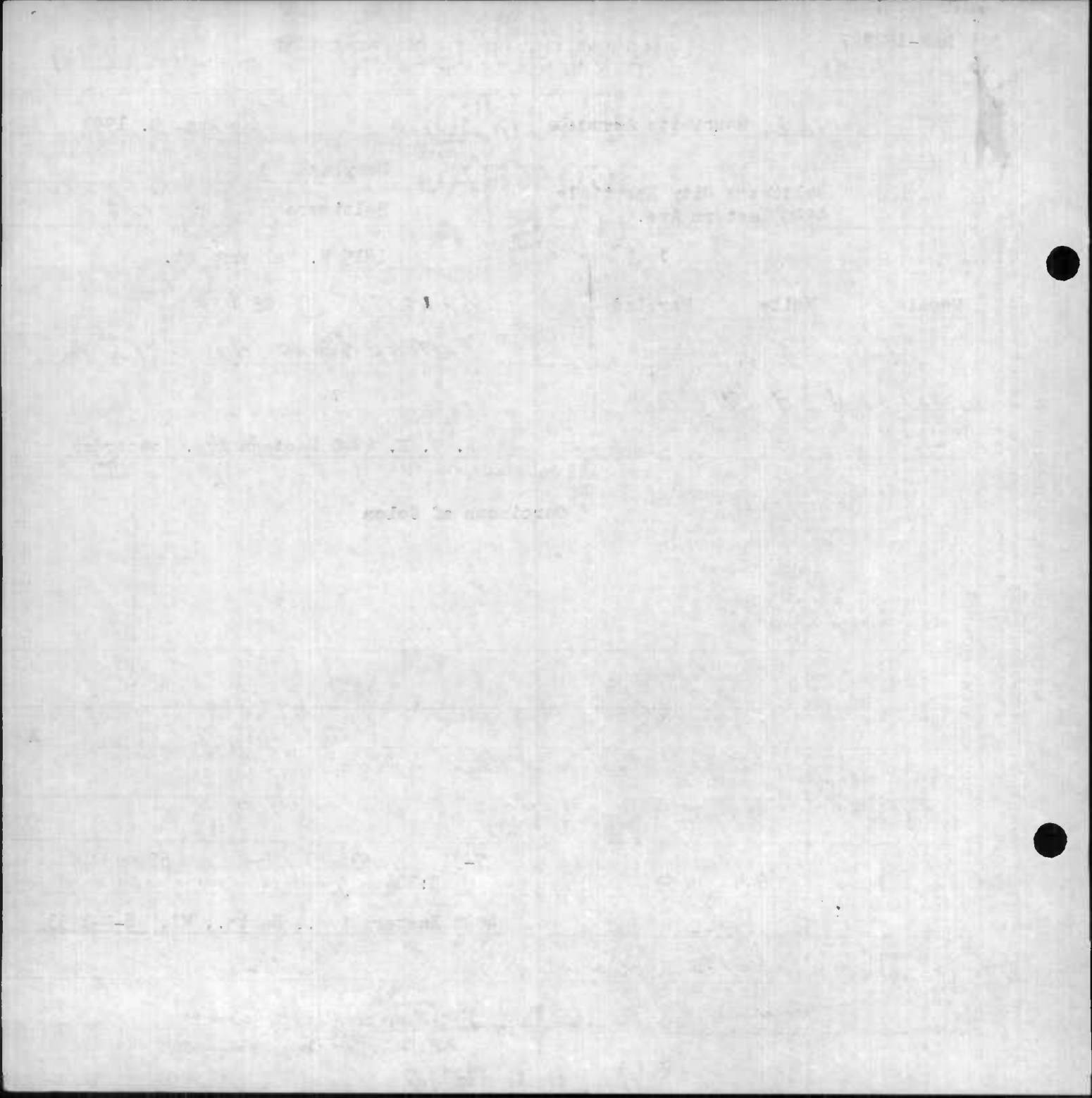
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Coronary sclerosis</b>		<b>?</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>Aug 4, 1953</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>August 4, 1953</b> to <b>August 5, 1953</b> that I last saw the deceased alive on <b>Aug 4, 1953</b> and that death occurred at <b>8:00 A.M.</b> from the causes and on the date stated above.							
23A. SIGNATURE <b>Ther. J. Clark</b>		23B. ADDRESS <b>3603 Belair Road</b>		23C. DATE SIGNED <b>8/6/53</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 8. 1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 6 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>		FUNERAL DIRECTOR <b>Phelps &amp; Son</b>		ADDRESS <b>2024 Orleans St 31</b>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A-524 MAF-172927 53 7090 BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 53 7090	
1. NAME OF DECEASED (Type or Print) <b>JULIA E. Henrietta Anzula ANZULA</b>			2. DATE OF DEATH <b>Aug. 4, 1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>20-01</b>		
c. Length of stay in Baltimore <b>1 50 yrs</b> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>1815 W. Mulberry St.</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Nov. 8, 1895</b>	9. AGE (In years last birthday) <b>57 77</b>	10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>EASTERN SHORE Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>BALLARD H BRYAN</b>			14. MOTHER'S MAIDEN NAME <b>?</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>B. C. H. 4940 Eastern Ave. (records)</b>		
18. <b>153X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Colon</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7-31</b> , 1953, to <b>8-4</b> , 1953 that I last saw the deceased alive on <b>8-4</b> , 1953, and that death occurred at <b>3:30A</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>H. J. Schuler</b>		23B. ADDRESS <b>4940 Eastern Ave., Balto., Md.</b>		23C. DATE SIGNED <b>8-4-1953</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 6, 1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Louisa Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>		25. FUNERAL DIRECTOR ADDRESS <b>3512 Frederick Ave.</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 6 1953</b>		REGISTRAR'S SIGNATURE <b>H. J. Schuler</b>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 53 7091
5-530  
53 7091

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Lillian F. Smith

2. DATE  
OF  
DEATH

8/4/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore 21-02

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

1178 Sargeant St.

D. STREET ADDRESS (If rural, give location)

1178 Sargeant St.

c. Length of stay in Baltimore

54

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

3/24/1896

9. AGE (In years last birthday)

57

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House work

10B. KIND OF BUSINESS OR INDUSTRY

at Home

11. BIRTHPLACE (State or foreign country)

Pittsburg, Pa.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Peter Curran

14. MOTHER'S MAIDEN NAME

Mary Sutton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

No

17. INFORMANT

Mrs Charles R. Harris Sargeant

ADDRESS

1178 ST.

18. 175X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

1 1/2 hr.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/18/32, 19, to 8/4/53, 19, that I last saw the deceased alive on 8/4/53, 19, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

H. S. Curran J. Curran

M. O.

23B. ADDRESS

1016 E. East L.

23C. DATE SIGNED

8/6/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/7/53

24C. NAME OF CEMETERY OR CREMATORY

Western Cem.

24D. LOCATION (City, town, or county)

Edmondson &amp; Longwood

DATE RECEIVED BY LOCAL REGISTRAR

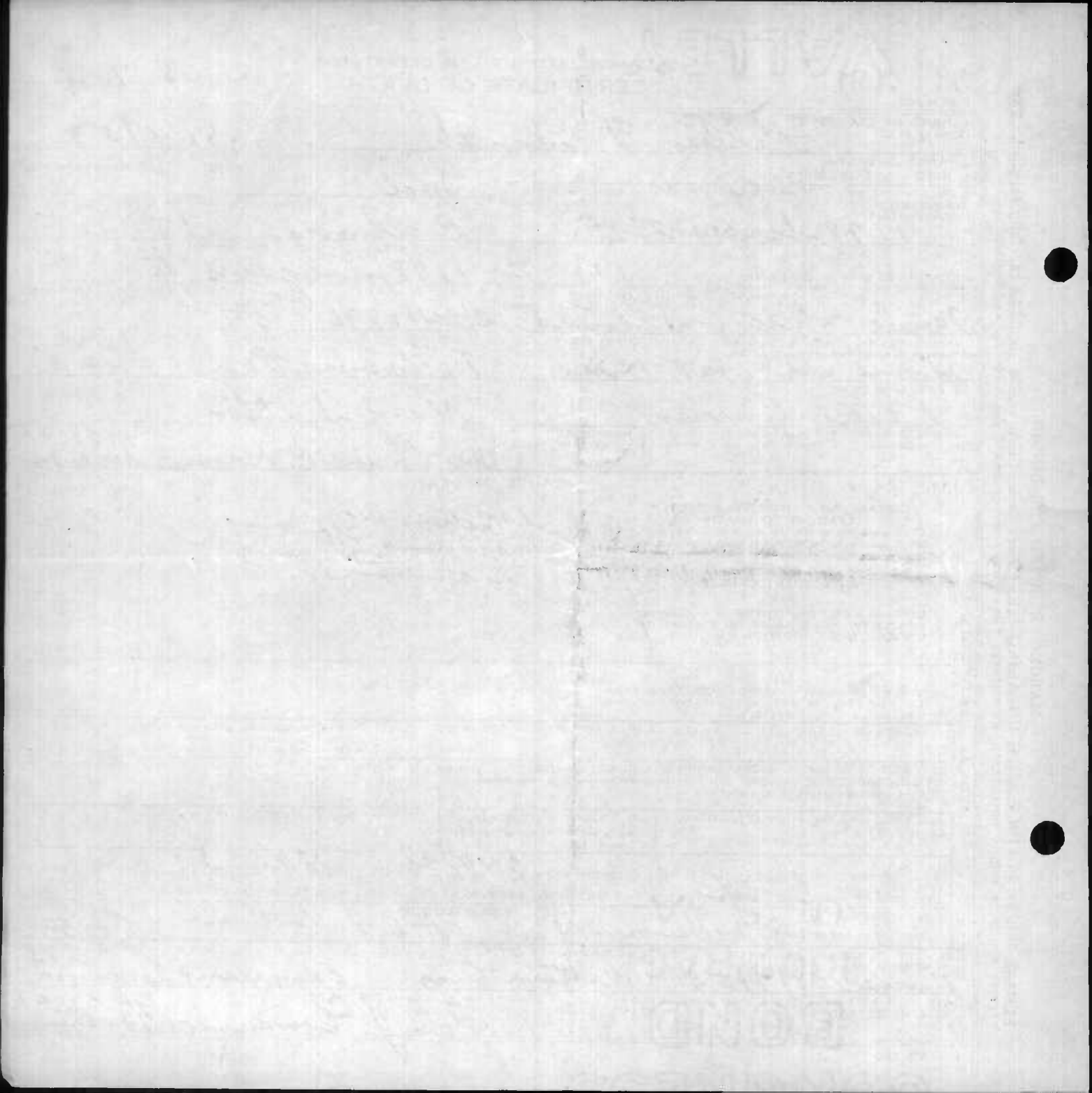
AUG 6 1953

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

John J. Bowman &amp; Son 34 Hollins





F. 425

X

53 7092

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7092

1. NAME OF DECEASED (Type or Print) <i>Jerome P. Fleishman</i>		2. DATE OF DEATH <i>Aug. 5, 1953</i>	
3. PLACE OF DEATH: A. <i>Baltimore City, Maryland</i> <i>Maryland</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>5352</i>	
D. LENGTH OF STAY IN BALTIMORE <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>411 Lambeth Road # 28</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>April 14, 1886</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Publisher</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Transportation</i>	9. AGE (In years last birthday) <i>67</i>
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Julius Fleishman</i>		14. MOTHER'S MAIDEN NAME <i>Bettie Herr</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Rena F. Syrop</i>		ADDRESS <i>Victoria Hotel N.Y.</i>	
18. <i>592X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Chronic glomerular nephritis</i> DUE TO <i>Uremia</i> DUE TO <i>Bacteremia</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>15 days</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>15 days</i>			
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <i>7/16</i> , 19 <i>53</i> , to <i>8/5</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>8/5</i> , 19 <i>53</i> , and that death occurred at <i>9:15 A.M.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>R. Keeshan</i>		23B. ADDRESS <i>Md. General Hospital</i>	
23C. DATE SIGNED <i>8/5/53</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>Aug 7-53</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Cremation</i>		24D. LOCATION (City, town, or county) (State) <i>Frederick Ave Balt, Md</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 6 1953</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>	
VS 150		25. FUNERAL DIRECTOR <i>Wm H. Ritzer</i>	
		ADDRESS <i>4101 Edmonstone Ave</i>	

MEDICAL CERTIFICATION

290 411

2

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **53 7093**

**53 7093**  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>DOMIS M. CANNON</b>		2. DATE OF DEATH <b>August 3, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF (not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>St. Joseph's Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 26-02</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>4220 Seidel Avenue</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>June 6, 1921</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>C*P Telephone Co.</b>	9. AGE (In years last birthday) <b>32</b> If Under 1 Year Months Days If Under 24 Hours Hours Min.
11. BIRTHPLACE (State or foreign country) <b>Balto. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Duvall</b>		14. MOTHER'S MAIDEN NAME <b>Ernestine Haycock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. George E. Cannon</b>		ADDRESS <b>4220 Seidel Ave.</b>	

18. <b>E976x</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Gunshot wound of the abdomen</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>4220 Seidel Avenue</b>		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>8-3-53 4:40 P.m.</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>shot self in abdomen</b>		
22. I certify that I took charge of the remains described above, held an <b>autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .				

23A. SIGNATURE <i>[Signature]</i>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>8-4-53</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8-6-53</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	

DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 6 1953</b>	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR <b>Wm. D. Tucker &amp; Sons Inc.</b>	ADDRESS <b>Balto. Md.</b>
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VS 151

**N 879.2**

**370 54**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100

200

300

400

500

600

700

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7094  
Registered No.

BIRTH NO. 53 7094

1. NAME OF DECEASED  
(Type or Print)

Tony Zaharas

(ZAHARIAS)

2. DATE  
OF  
DEATH

Aug. 4, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Balto. Md.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

26-03

D. STREET ADDRESS (If rural, give location)

1901 W. Pratt Street

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

unknown

9. AGE (In years  
last birthday)

47

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Cook

10B. KIND OF BUSINESS OR  
INDUSTRY

Restaurant

11. BIRTHPLACE (State or foreign country)

Greece

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

232-03-4511

17. INFORMANT

ADDRESS

Anthony Trintis 214 E. Lexington

18. 490X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

LOBAR PNEUMONIA E  
FULMINATING TOXEMIA

4 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH. ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

M.

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 1, 1953, to Aug 4, 1953, that I last saw the  
deceased alive on Aug 4, 1953, and that death occurred at 7 P. m., from the causes and on the date stated above.

23A. SIGNATURE

James E. Rowe

M. D.

23B. ADDRESS

St. Agnes Hospital

23C. DATE SIGNED

8/4/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8-6-53

24C. NAME OF CEMETERY OR CREMATORY

Greek Cem.

24D. LOCATION (City, town, or county)

Windsor Mill Rd

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

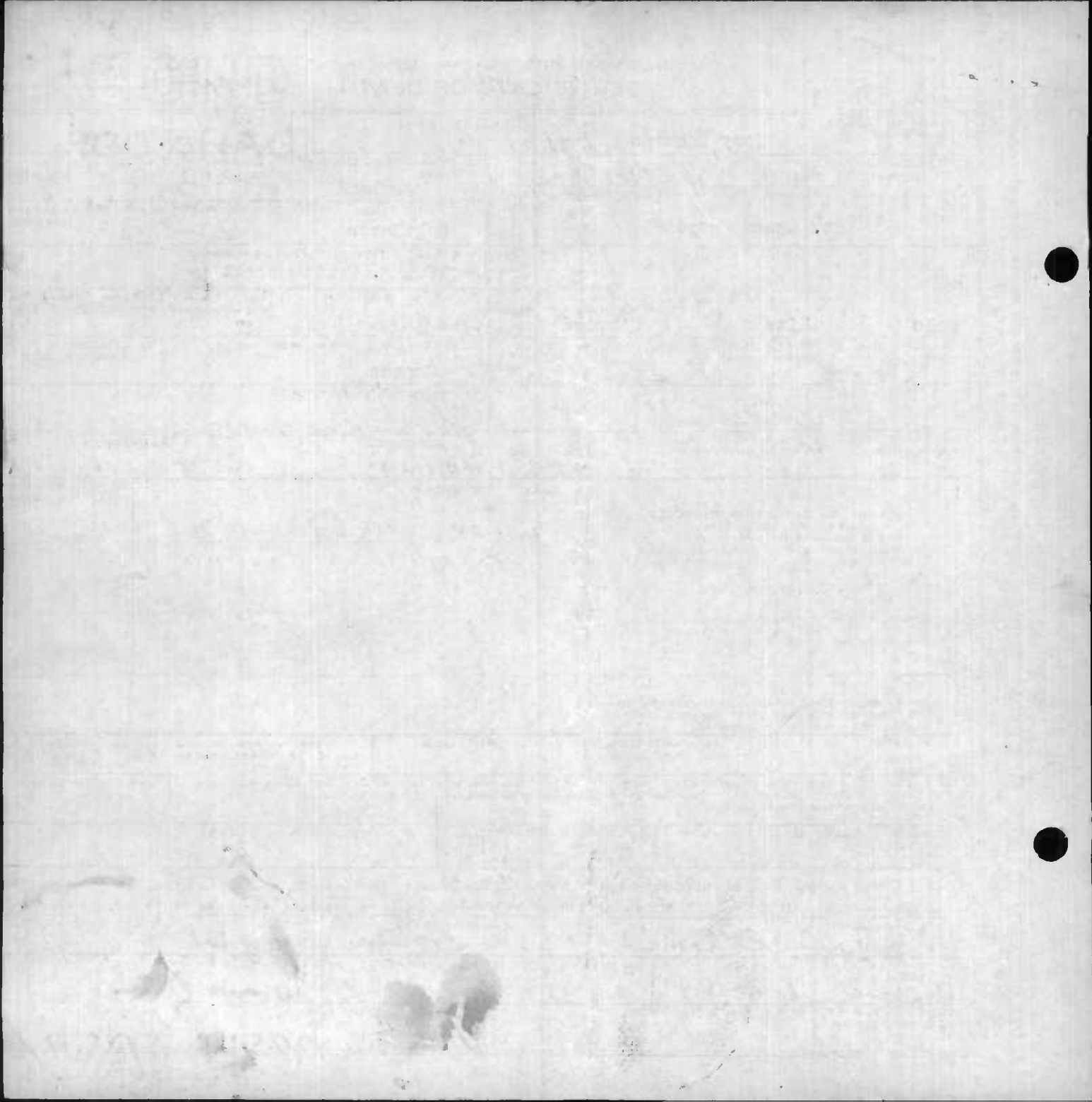
REGISTRAR'S SIGNATURE

Huntington B. Williams

25. FUNERAL DIRECTOR

ADDRESS

Kamoras Inc. 440 E. North A





W-352 53 7095		CORRECTED 8/6/53 ES		BALTIMORE CITY HEALTH DEPARTMENT		53 7095	
BIRTH NO. 51-22916				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Joseph R. Widomski</u>				2. DATE OF DEATH <u>August 4, 1953</u>			
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>HRH 4A</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u>			
B. FULL NAME OF (If not in hospital or institution, give street address or location) <u>JOHNS HOPKINS HOSPITAL</u>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>10-02</u>			
c. Length of stay in Baltimore <u>LIFE</u>				D. STREET ADDRESS (If rural, give location) <u>1121 Wilmat St.</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	B. DATE OF BIRTH <u>10-3-51</u>	9. AGE (In years last birthday) <u>22</u>	If Under 1 Year Months: Days	If Under 24 Hours Hours: Min.	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Casimir Widomski</u>			14. MOTHER'S MAIDEN NAME <u>CHARLOTTE LEIGHTON</u>		17. INFORMANT ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>		
18. <u>010X</u> CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Tuberculous meningitis</u>				(A) <u>Bacterial meningitis</u>			
ANTECEDENT CAUSES				(B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Hypotension (Hypoelectrolithemia)</u>							
19A. DATE OF OPERATION <u>7-8</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-8</u> , 19 <u>53</u> , to <u>8-4</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>8-4</u> , 19 <u>53</u> , and that death occurred at <u>7:10 P.m.</u> , from the causes and on the date stated above.							
23A. SIGNATURE <u>Herman Dubler Jr.</u>				23B. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>		23C. DATE SIGNED <u>5 Aug 53</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>AUG 7 1953</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY CEM</u>		24D. LOCATION (City, town, or county) (State) <u>GERMAN HILL RD MD</u>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>Huntington Williams, M.D.</u>		25. FUNERAL DIRECTOR <u>Koppel Bros</u>		ADDRESS <u>1800 E LOMBARD ST</u>	

Dr. Hardy called Dr. Pinkerton for this info

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5-000 53 7096		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 53 7096	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>Dorothy Shaw</i>			2. DATE OF DEATH <i>Aug 5, 1953</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Med. Bldg 4</i>			4. USUAL RESIDENCE (Where deceased lived. If in institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>15-01</i>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>JOHNS HOPKINS HOSPITAL</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 17</i>		
c. Length of stay in Baltimore <i>Life</i>			D. STREET ADDRESS (If rural, give location) <i>1734 N. Calhoun St</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Caucasian</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>1-24-'08</i>	9. AGE (In years last birthday) <i>45</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H. Wife</i>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Charles Owens</i>			14. MOTHER'S MAIDEN NAME <i>Lillie</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>None</i>		
17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>			ADDRESS		
18. <i>204.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Chronic myeloid leukemia</i>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ (C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>7-13-53</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>7-13-53</i> , 19 <i>53</i> , to <i>8-5-53</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>8-5-53</i> , 19 <i>53</i> and that death occurred at <i>9:20 a.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Henry N. Wagner Jr.</i>		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>8/5/53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/9/53</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Arbutus Memo. Pk., Inc. Arbutus, Md.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>					
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 6 1953</i>		REGISTRAR'S SIGNATURE <i>Hamilton Williams, M.D.</i>		25. FUNERAL DIRECTOR <i>Geo. S. Kelton</i>	
ADDRESS <i>1303 Presstman St.</i>					

STATE OF FLA.

7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-460  
53 7097

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7097

Registered No.

BIRTH NO.		2. DATE OF DEATH Aug. 4, 1953	
1. NAME OF DECEASED (Type or Print) <b>Louise Delaphine Wheeler</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY	
3. PLACE OF DEATH: A. Baltimore City, Maryland		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto.</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>1831 Madison Ave.</b>		O. STREET ADDRESS (If rural, give location) <b>1831 Madison Ave.</b>	
c. Length of stay in Baltimore Life Yrs. Mos. Days		8. DATE OF BIRTH <b>10/3/20</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	9. AGE (In years last birthday) <b>32</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Wife</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hayes Junery</b>		14. MOTHER'S MAIDEN NAME <b>Alverta Washington</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-16-2456</b>	
17. INFORMANT <b>Sarah Cager</b>		ADDRESS <b>1808 Madison Ave.</b>	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinomatosis</b> DUE TO ANTECEDENT CAUSES <b>Carcinoma of Cervix</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b> <b>6 mo</b>
19A. DATE OF OPERATION <b>July 7, 1953</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK	
22. I hereby certify that I attended the deceased from <b>July 7, 1953</b> , to <b>Aug 4, 1953</b> , that I last saw the deceased alive on <b>Aug 4, 1953</b> , and that death occurred at <b>6:45 p. m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>McDonald Bando</b>		23B. ADDRESS <b>2445 Grand Hill Ave</b>	
23C. DATE SIGNED <b>8-6-53</b>		24. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/7/53</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn</b>		24D. FUNERAL DIRECTOR <b>Geo. G. Kelson</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>Huntington</b>		ADDRESS <b>1303 Presstman St.</b>	
AUG 6 1953 <b>Kelson</b>			

James E. H. H. H. H.

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James E. H. H. H. H.

James E. H. H. H. H.



MAF- 172873 **10-529**  
53 7098BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7098  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Walter Banister

2. DATE  
OF  
DEATH

Aug. 3, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR INSTITUTION

Baltimore City Hospitals

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

4-02

4940 Eastern ave.

D. STREET ADDRESS (If rural, give location)

719 W. Fayette St.

c. Length of stay in Baltimore

45 yrs.

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Sep.

8. DATE OF BIRTH

May 15, 1899

9. AGE (In years  
last birthday)

54

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Ton Banister

14. MOTHER'S MAIDEN NAME

Annie Gross

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

no

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

218-03-7234

17. INFORMANT

ADDRESS

B. C. H. 4940 Eastern Ave. (records)

18.

002X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Far Advanced Pulmonary Tuberculosis

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-30, 1953 to 8-3, 1953, that I last saw the  
deceased alive on 8-3, 1953, and that death occurred at 8:15P m., from the causes and on the date stated above.

23A. SIGNATURE

H. J. Nelson M.D.

23B. ADDRESS

4940 Eastern Ave., Balto. Md.

23C. DATE SIGNED

8-3-1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8/8/53

24C. NAME OF CEMETERY OR CREMATORY

Mt Auburn

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Geo. G. Nelson 1303 Presstman St.

100-12307

100-12307

100-12307

100-12307

100-12307

100-12307

100-12307

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

53 7099  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>WILLIAM DIMLING</b>			2. DATE OF DEATH <b>August 4, 1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>915 N. Lakewood Ave.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION _____			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
D. STREET ADDRESS (If rural, give location) <b>915 N. Lakewood Ave.</b>			E. LENGTH OF STAY IN BALTIMORE <b>life</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>April 26, 1880</b>		9. AGE (In years last birthday) <b>73</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>paperhanger</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>own business</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Frederick W. Dimling</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT ADDRESS <b>Frank J. Vitak, friend, above</b>		

18. <b>442X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH <b>myocardial failure</b> <b>chronic myocarditis</b> <b>cardio-vascular-renal</b> <b>arterio sclerosis</b>	INTERVAL BETWEEN ONSET AND DEATH <b>aug 2-1953</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Jan 4, 1952</b> to <b>Aug 4, 1953</b> , that I last saw the deceased alive on <b>Aug 2, 1953</b> , and that death occurred at <b>12 P. m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Louis R. Krumm</b>		23B. ADDRESS <b>722 No. Kenwood Ave</b>		23C. DATE SIGNED <b>Aug 5/53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 7, 1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <b>H. E. Taylor</b>		25. FUNERAL DIRECTOR ADDRESS <b>Schimmupke Funeral Home, Inc. 2601-3-5 E. Madison St.</b>	

56524

DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

NAME OF DECEASED

RES. 2, Jackson Ave.

DATE OF DEATH

PLACE

CAUSE OF DEATH

IMMEDIATE CAUSE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION OF DECEASED

INDUSTRY OR OCCUPATION

PREVIOUS ILLNESS

DATE OF LAST ILLNESS

DATE OF EXAMINATION

DATE OF SIGNATURE

DATE OF SIGNATURE

DATE OF SIGNATURE

DATE OF SIGNATURE

DATE OF SIGNATURE

DATE OF SIGNATURE

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DATE OF SIGNATURE

53 7100

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

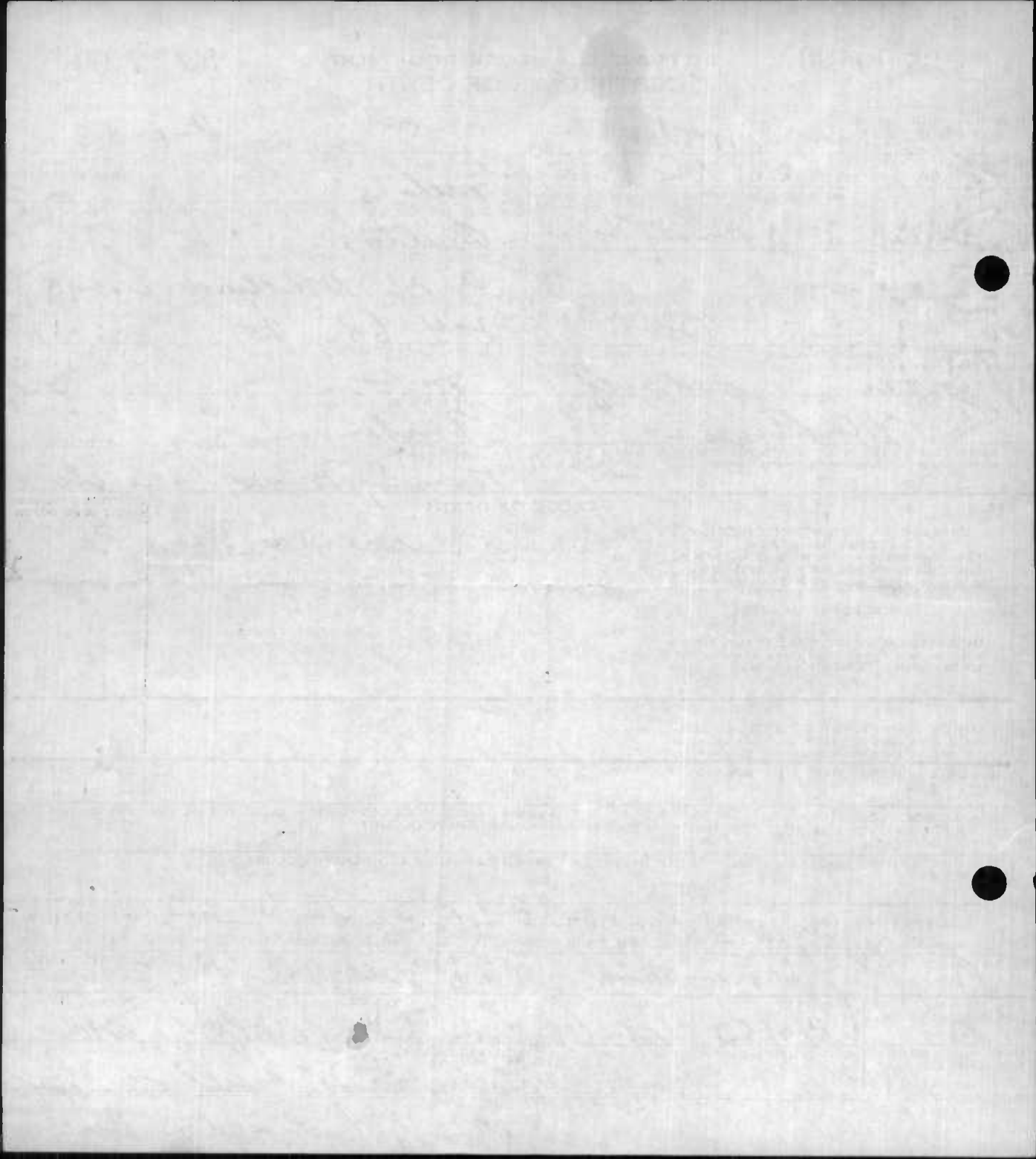
Registered No. 53 7100

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>John Tinsley Lane</i>			2. DATE OF DEATH <i>8-6-53</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>2101 W. Cold Spring</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY		
5. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Bar-Wil-Ba Nursing Home</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto.</i>		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <i>2121 Madison Ave</i>		
5. SEX <i>m</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>m</i>	8. DATE OF BIRTH <i>7-4-68</i>		9. AGE (In years last birthday) <i>85</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Juniper</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>on self</i>	11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Unknown</i>			14. MOTHER'S MAIDEN NAME <i>Unknown?</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Nursing Home records</i>		

18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cardio Vascular Disease?</i>	CAUSE OF DEATH (A) <i>Cardio Vascular Disease?</i> DUE TO (B) _____ DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>July 12, 1953</i> , to <i>Aug 6, 1953</i> , that I last saw the deceased alive on <i>July 25, 1953</i> , and that death occurred at <i>32</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>H. R. Johnson</i> M. D.		23B. ADDRESS <i>403 W. 4th St. Bg</i>		23C. DATE SIGNED <i>8-6-53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>B</i>	24B. DATE <i>8/6/53</i>	24C. NAME OF CEMETERY OR CREMATORY <i>mt. Auburn</i>	24D. LOCATION (City, town, or county) (State) <i>Balto. Md</i>		
DATE RECEIVED BY LOCAL REGISTRAR <i>Aug 6 1953</i>	REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i>	25. FUNERAL DIRECTOR <i>W. Sullivan Jr</i>	ADDRESS <i>10117 N. Arlington Ave</i>		





A-352  
53 7101BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7101  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARY M. ADAMS

2. DATE  
OF  
DEATH

8/5/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

MARYLAND

B. COUNTY

BALTIMORE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

9-06

D. STREET ADDRESS (If rural, give location)

1606 EAST 28<sup>th</sup> ST.

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

MAR. 17, 1878

9. AGE (In years  
last birthday)

75

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR  
INDUSTRY

OWN HOME

11. BIRTHPLACE (State or foreign country)

BALTIMORE, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

GEORGE WILLIAMS

14. MOTHER'S MAIDEN NAME

ELIZABETH HAHN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

EDITH CLAUICE, 1606 E. 28<sup>th</sup> Street

18. 540.0 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) g. I. Hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Gastric Ulcer

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ HOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-4, 1953, to 8-5, 1953, that I last saw the  
deceased alive on 8-5, 1953, and that death occurred at 11:40 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Louise Schaefer

M. D.

23B. ADDRESS

Union Memorial Hosp.

23C. DATE SIGNED

8-6-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

8/8/53

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

ADDRESS

J. M. Book, Jr., 1217 16<sup>th</sup> Paul St.

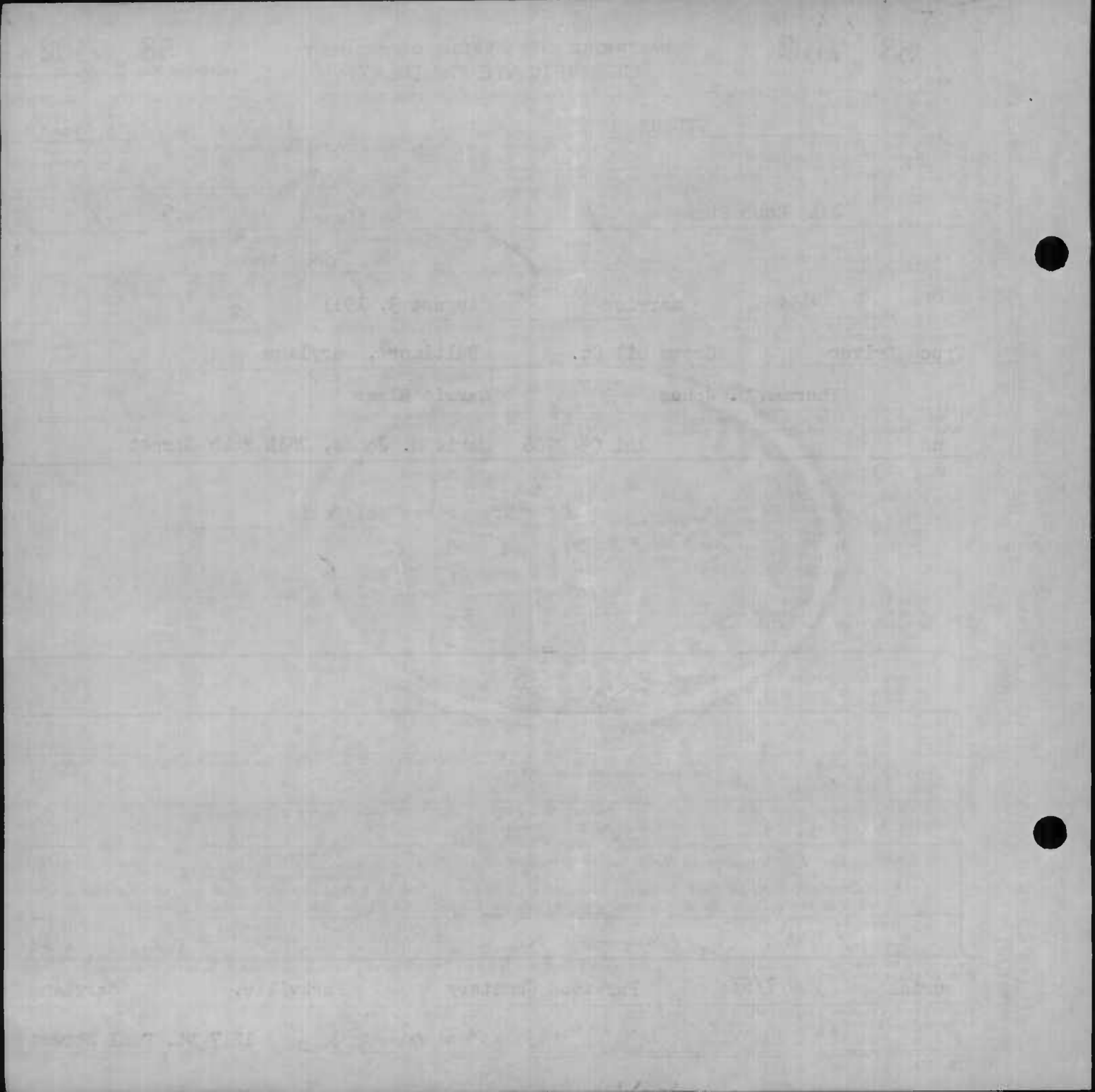
ATTESTING THE DEATH OF  
CERTIFICATE OF DEATH

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

<p><i>[Faint, illegible text]</i></p>	<p><b>Cause of Death</b></p> <p><i>[Faint, illegible text]</i></p>
<p><i>[Faint, illegible text]</i></p>	<p><b>Place of Death</b></p> <p><i>[Faint, illegible text]</i></p>
<p><i>[Faint, illegible text]</i></p>	<p><b>Signature of Registrar</b></p> <p><i>[Faint, illegible text]</i></p>

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				53 7102 Registered No.	
BIRTH NO. J-520 53 7102					
1. NAME OF DECEASED (Type or Print) <b>WILBUR WALTER JONES</b>				2. DATE OF DEATH <b>August 4, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF (not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>2614 Robb Street</b>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>9-07</b>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____				D. STREET ADDRESS (If rural, give location) <b>2614 Robb Street</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>August 3, 1911</b>	9. AGE (in years last birthday) <b>42</b>	If Under 1 Year Months: _____ Days: _____ If Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Crown Oil Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Thurman W. Jones</b>			14. MOTHER'S MAIDEN NAME <b>Carrie Blake</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>141 05 9706</b>		17. INFORMANT ADDRESS <b>Marie M. Jones, 2614 Robb Street</b>	
18. <b>420.1</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary artery sclerosis</b> (A) _____ DUE TO _____ ANTECEDENT CAUSES (B) _____ DUE TO _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Pulmonary edema</b>					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <u>autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>Joseph A. Jachinzyk</b>		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <b>August 5, 1953</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>8/7/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Parkville, Maryland</b>		25. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook, Inc., 1217 St. Paul Street</b>			
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <b>Thurston Williams, M.D.</b>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7103  
53 7103

AMENDED 9/2/53 ES  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7103

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Howard Simms

2. DATE  
OF  
DEATH

7-17-1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR INSTITUTION location)

Baltimore City Hospitals

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
Baltimore township)

4940 Eastern Ave.

life

Yrs.  
Mos.  
Days

c. Length of stay in Baltimore

D. STREET ADDRESS (If rural, give location)

218 N. Ellwood Avenue #24

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Jan. 30, 1891

9. AGE (In years  
last birthday)

63

If Under 1 Year  
Months Days

If Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Thomas Simms

14. MOTHER'S MAIDEN NAME

Mary Hinkle

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

B.C.H. 4940 Eastern Ave. (record)

18. 002X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Respiratory Failure

19. DUE TO Pulmonary tuberculosis, far advanced  
active

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO Pulmonary emphysema

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?  
YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3 - 4 - , 1953, to 7 - 17 - , 1953 that I last saw the  
deceased alive on 7 - 17 - 1953, and that death occurred at 8:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE

H. J. Williams

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

7-17-1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL AUG 6 1953

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Huntington Williams

ADDRESS

AUG 6 1953

VS 150

53 7103

See query reply in Document file.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-172537		CERTIFICATE AMENDED 9/14/53 ES		BALTIMORE CITY HEALTH DEPARTMENT		53 7104		Registered No.	
BIRTH NO.		53 7104		CERTIFICATE OF DEATH		53 7104		Registered No.	
1. NAME OF DECEASED (Type or Print)				Clara Young				2. DATE OF DEATH July 21-1953	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY					
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE Baltimore City Hospitals 4940 Eastern Ave.				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-0 S					
c. Length of stay in Baltimore 30yrs				D. STREET ADDRESS (If rural, give location) 1821 East Madison St. zone 5					
5. SEX F		6. COLOR OR RACE N		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH ?		9. AGE (In years last birthday) 63?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? ?	
13. FATHER'S NAME Frank Young				14. MOTHER'S MAIDEN NAME ?					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT 4940 Eastern Ave. ADDRESS Records: Baltimore City Hospitals			
18. 286.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Uremia DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Malnutrition and acute cardiac failure. DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH Uremia Malnutrition and acute cardiac failure.				INTERVAL BETWEEN ONSET AND DEATH Unknown	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 7-21-, 1953, to 7-21-, 1953, that I last saw the deceased alive on 7-21-, 1953, and that death occurred at 9.20PM., from the causes and on the date stated above.									
23A. SIGNATURE H. J. Williams, M.D.				23B. ADDRESS 4940 Eastern Ave., Baltimore, Md.				23C. DATE SIGNED July 22-53	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL		24D. LOCATION (City, town, or county) AUG 6 1953		(State)	
DATE RECEIVED BY LOCAL REGISTRAR AUG 6 1953		REGISTRAR'S SIGNATURE Huntington Williams, M.D.		25. FUNERAL DIRECTOR H. J. Williams, M.D.		ADDRESS			

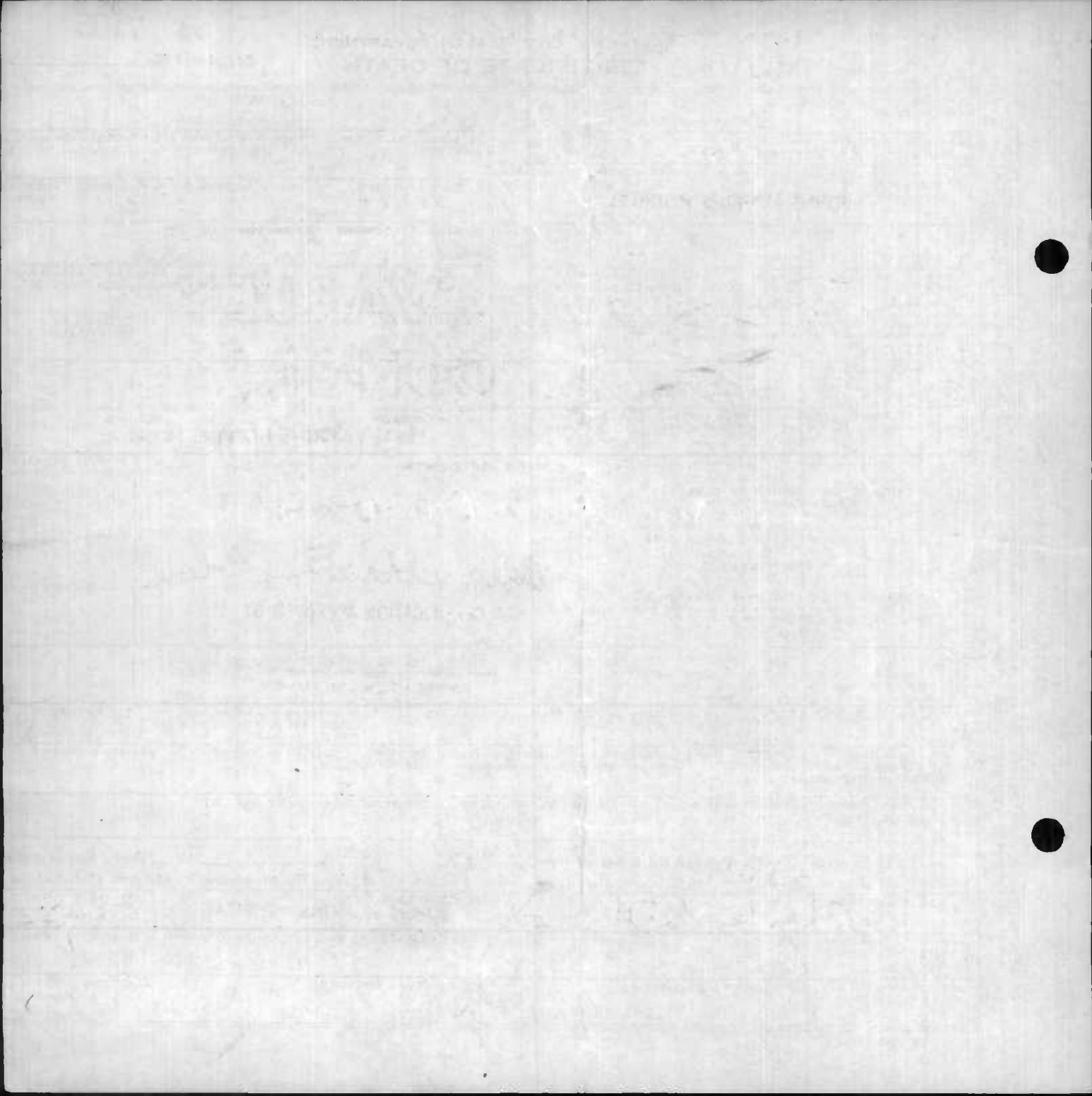
See query reply in Document file.

3462

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Baltimore City Health Department CERTIFICATE OF DEATH				Registered No. _____	
1. NAME OF DECEASED (Type or Print) <i>Marcella Cornish</i>				2. DATE OF DEATH <i>Aug. 5, 1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Acc. Room</i>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Ind.</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 5-01</i>	
C. Length of stay in Baltimore <i>Life</i>				D. STREET ADDRESS (If rural, give location) <i>527 N. Central Ave.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>Sept. 6, 1871</i>	9. AGE (In years last birthday) <i>81</i>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>			11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MD</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>SAMUEL AGUILLA</i>			14. MOTHER'S MAIDEN NAME <i>PATIENCE SAVOY</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		
18. <i>153X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Carcinomatosis</i> DUE TO ANTECEDENT CAUSES <i>Adenocarcinoma, colon</i> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>CERTIFICATION APPROVED BY</i> <i>William H. [Signature]</i> M. D. CHIEF OR ASST. MEDICAL EXAMINER.				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>8/5</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		19C. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>8/5</i> , 19 <i>53</i> , to <i>8/5</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>8/5</i> , 19 <i>53</i> , and that death occurred at <i>12:35 A.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Chester E. Herrod</i>		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>5 Aug 53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>8-8-53</i>	24C. NAME OF CEMETERY OR CREMATORY <i>MT. CALVARY</i>		24D. LOCATION (City, town, or county) (State) <i>A.A. County, MD</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 6 1953</i>		REGISTRAR'S SIGNATURE <i>William H. [Signature]</i>		25. FUNERAL DIRECTOR ADDRESS <i>Wm. H. [Signature] 1304 N. Central Ave.</i>	



N-426  
53 7106BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7106  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>Edward A Neiker</b>			2. DATE OF DEATH <b>Aug. 6<sup>TH</sup> 1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>BALTO.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO. 6.</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>4012 W. Overlea Ave</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>27-05</b>		
C. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>4012 Overlea Ave</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b>	8. DATE OF BIRTH <b>Nov. 22<sup>ND</sup> 1863</b>	9. AGE (in years, last birthday) <b>89</b>	10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>			11. BIRTHPLACE (State or foreign country) <b>BALTO. CITY MD</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>August Neiker</b>		
14. MOTHER'S MAIDEN NAME <b>Caroline Meyers</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		
16. SOCIAL SECURITY NO. <b>no</b>			17. INFORMANT ADDRESS <b>Mrs Christ Neiker - 4012 W. Overlea Ave</b>		
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Chronic myocardial infarction</b> DUE TO <b>Arterio-sclerosis</b> 10 yrs INTERVAL BETWEEN ONSET AND DEATH					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 1953</b> to <b>Aug 6<sup>th</sup> 1953</b> that I last saw the deceased alive on <b>Aug 5<sup>th</sup> 1953</b> and that death occurred at <b>4 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Edw. H. Brown</b>		23B. ADDRESS <b>4012 W. Overlea Ave</b>		23C. DATE SIGNED <b>8/6/53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/8/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Louder Park Cem.</b>	
24D. LOCATION (City, town, or county) <b>BALTO.</b>		24E. STATE <b>MD</b>		25. FUNERAL DIRECTOR ADDRESS <b>CASSARD Funeral Home 7401 Belair Rd. BALTO. 6. MD.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 7 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>		25. FUNERAL DIRECTOR ADDRESS <b>CASSARD Funeral Home 7401 Belair Rd. BALTO. 6. MD.</b>	

Dr. Benson

1. W. Overlea Ave.



8-453

53 7107

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7107

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

2. DATE OF DEATH

August 6/1953

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Temple B. COUNTY Adams

C. CITY OR TOWN Baltimore 13-01

D. STREET ADDRESS (If rural, give location)

Same

5. SEX

Female

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Oct 30/1895 97

9. AGE (In years, last birthday)

If Under 1 Year Months Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Abraham Plant

14. MOTHER'S MAIDEN NAME

Matilda Delery

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mr. IRVING Plant 4037 W. Coles Spring Ave

ADDRESS

18.

304X I  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Starvation + cachexia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

INJURY

M.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from August 4, 1953 to August 6, 1953, that I last saw the deceased alive on August 6, 1953, and that death occurred at 6:15 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 7 1953

VS 150

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

Form No. 1

REPORT OF INVESTIGATION

TO : SAC, NEW YORK  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]

[Illegible text follows]

REFERENCE IS MADE TO THE REPORT OF THE NEW YORK OFFICE DATED [Illegible] AND THE REPORT OF THE NEW YORK OFFICE DATED [Illegible].

[Illegible text follows]

IT IS REQUESTED THAT YOU ADVISE THE NEW YORK OFFICE OF ANY DEVELOPMENTS.

[Illegible text follows]

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 53 7108

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <u>Mary Louise Storms</u>			2. DATE OF DEATH <u>Aug. 5, 1953</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>3613 Elmley Ave.</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore 26-03</u>		
C. Length of stay in Baltimore <u>5</u> Yrs. <u>Mon.</u> <u>Days</u>			D. STREET ADDRESS (If rural, give location) <u>3613 Elmley Ave.</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 25, 1866</u>		9. AGE (in years last birthday) <u>87</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Fredrick H. Bartell</u>			14. MOTHER'S MAIDEN NAME <u>Henrietta Kruger</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____		16. SOCIAL SECURITY NO. _____	17. INFORMANT ADDRESS <u>Wm. Henry Storms Ridgeway Avenue Lutherville Md.</u>		

18. <u>422.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) <u>Cardiac Decompenstation</u> DUE TO (B) <u>Arteriosclerosis, Heart</u> DUE TO (C) <u>Arthritis</u>	INTERVAL BETWEEN ONSET AND DEATH <u>64 yrs</u> <u>16 yrs</u> <u>20 yrs</u>
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II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Aug 1, 1953 to Aug 5, 1953, that I last saw the deceased alive on Aug 1, 1953 and that death occurred at 4:30 PM from the causes and on the date stated above.

23A. SIGNATURE <u>Bennett G. Stoen</u>		23B. ADDRESS <u>Hagerstown, Md.</u>		23C. DATE SIGNED <u>8/5/53</u>	
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24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>Aug 8, 1953</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
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DATE RECEIVED BY LOCAL REGISTRAR <u>AUG 7 1953</u>	REGISTRAR'S SIGNATURE <u>Huntington Williams, Jr.</u>	25. FUNERAL DIRECTOR <u>H. Sander &amp; Sons Inc.</u>	ADDRESS <u>North Ave. &amp; Broadway</u>
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*Sep 7. Sander*

MEDICAL CERTIFICATION

MINISTRE DE LA SANTE  
CERTIFICATE OF DEATH

1. Name of the deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of the physician	
10. Signature of the registrar		11. Signature of the coroner		12. Signature of the medical examiner	
13. Signature of the funeral home		14. Signature of the family		15. Signature of the witnesses	
16. Signature of the burial society		17. Signature of the cemetery		18. Signature of the funeral home	
19. Signature of the family		20. Signature of the witnesses		21. Signature of the burial society	
22. Signature of the cemetery		23. Signature of the funeral home		24. Signature of the family	
25. Signature of the witnesses		26. Signature of the burial society		27. Signature of the cemetery	
28. Signature of the funeral home		29. Signature of the family		30. Signature of the witnesses	
31. Signature of the burial society		32. Signature of the cemetery		33. Signature of the funeral home	
34. Signature of the family		35. Signature of the witnesses		36. Signature of the burial society	
37. Signature of the cemetery		38. Signature of the funeral home		39. Signature of the family	
40. Signature of the witnesses		41. Signature of the burial society		42. Signature of the cemetery	
43. Signature of the funeral home		44. Signature of the family		45. Signature of the witnesses	
46. Signature of the burial society		47. Signature of the cemetery		48. Signature of the funeral home	
49. Signature of the family		50. Signature of the witnesses		51. Signature of the burial society	
52. Signature of the cemetery		53. Signature of the funeral home		54. Signature of the family	
55. Signature of the witnesses		56. Signature of the burial society		57. Signature of the cemetery	
58. Signature of the funeral home		59. Signature of the family		60. Signature of the witnesses	
61. Signature of the burial society		62. Signature of the cemetery		63. Signature of the funeral home	
64. Signature of the family		65. Signature of the witnesses		66. Signature of the burial society	
67. Signature of the cemetery		68. Signature of the funeral home		69. Signature of the family	
70. Signature of the witnesses		71. Signature of the burial society		72. Signature of the cemetery	
73. Signature of the funeral home		74. Signature of the family		75. Signature of the witnesses	
76. Signature of the burial society		77. Signature of the cemetery		78. Signature of the funeral home	
79. Signature of the family		80. Signature of the witnesses		81. Signature of the burial society	
82. Signature of the cemetery		83. Signature of the funeral home		84. Signature of the family	
85. Signature of the witnesses		86. Signature of the burial society		87. Signature of the cemetery	
88. Signature of the funeral home		89. Signature of the family		90. Signature of the witnesses	
91. Signature of the burial society		92. Signature of the cemetery		93. Signature of the funeral home	
94. Signature of the family		95. Signature of the witnesses		96. Signature of the burial society	
97. Signature of the cemetery		98. Signature of the funeral home		99. Signature of the family	
100. Signature of the witnesses		101. Signature of the burial society		102. Signature of the cemetery	

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

53 7109  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*SARAH ALICE ROGERS*

2. DATE  
OF  
DEATH

*AUG 5, 1953*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

*331 E 30th St.*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

*Md.*

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore 12-02*

D. STREET ADDRESS (If rural, give location)

*331 E. 30th St.*

Length of stay in Baltimore

*38 yrs*

5. SEX

*F*

6. COLOR OR RACE

*W*

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

*Widowed*

8. DATE OF BIRTH

*July 20, 1860*

9. AGE (In years last birthday)

*93*

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Housewife*

10B. KIND OF BUSINESS OR INDUSTRY

*- - -*

11. BIRTHPLACE (State or foreign country)

*Somerset County Md.*

12. CITIZEN OF WHAT COUNTRY?

*USA*

13. FATHER'S NAME

*John W. Thomas*

14. MOTHER'S MAIDEN NAME

*Susan Taylor*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or no or unknown) (If yes, give war or dates of service)

*no*

16. SOCIAL SECURITY NO.

*none*

17. INFORMANT

*Miss Mary T. Rogers 331 E. 30th St.*

ADDRESS

18. *191x*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

*Myocardial failure*

(B)

DUE TO

*Senile Arteriosclerosis*

(C)

*Basal Cell Epithelioma face + skull*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *June*, 19*53* to *8-5*, 19*53*, that I last saw the deceased alive on *8-4*, 19*53*, and that death occurred at *8-5* m., from the causes and on the date stated above.

23A. SIGNATURE

*C. L. Ewald*

23B. ADDRESS

*36 York Court*

23C. DATE SIGNED

*8-6-53*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*July 7, 1953*

24C. NAME OF CEMETERY OR CREMATORY

*Loudon Park Cemetery*

24D. LOCATION (City, town, or county)

*Baltimore Md.*

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Huntington Williams*

25. FUNERAL DIRECTOR

*HENRY SANDER & SONS, INC.*

ADDRESS

*Baltimore Md.*

*Seg. F. Sander*

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of medical examiner		12. Signature of health officer	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of interment		18. Signature of cremation		19. Signature of other		20. Signature of other	
21. Signature of other		22. Signature of other		23. Signature of other		24. Signature of other	
25. Signature of other		26. Signature of other		27. Signature of other		28. Signature of other	
29. Signature of other		30. Signature of other		31. Signature of other		32. Signature of other	
33. Signature of other		34. Signature of other		35. Signature of other		36. Signature of other	
37. Signature of other		38. Signature of other		39. Signature of other		40. Signature of other	
41. Signature of other		42. Signature of other		43. Signature of other		44. Signature of other	
45. Signature of other		46. Signature of other		47. Signature of other		48. Signature of other	
49. Signature of other		50. Signature of other		51. Signature of other		52. Signature of other	
53. Signature of other		54. Signature of other		55. Signature of other		56. Signature of other	
57. Signature of other		58. Signature of other		59. Signature of other		60. Signature of other	
61. Signature of other		62. Signature of other		63. Signature of other		64. Signature of other	
65. Signature of other		66. Signature of other		67. Signature of other		68. Signature of other	
69. Signature of other		70. Signature of other		71. Signature of other		72. Signature of other	
73. Signature of other		74. Signature of other		75. Signature of other		76. Signature of other	
77. Signature of other		78. Signature of other		79. Signature of other		80. Signature of other	
81. Signature of other		82. Signature of other		83. Signature of other		84. Signature of other	
85. Signature of other		86. Signature of other		87. Signature of other		88. Signature of other	
89. Signature of other		90. Signature of other		91. Signature of other		92. Signature of other	
93. Signature of other		94. Signature of other		95. Signature of other		96. Signature of other	
97. Signature of other		98. Signature of other		99. Signature of other		100. Signature of other	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **53 7110**

**53 7110**  
BIRTH NO.

1. NAME OF DECEASED (Type or Print)		<b>PRESTON JOHNSON</b>		2. DATE OF DEATH <b>August 2, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 3-02</b>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>102 Albemarle Street</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <b>2-11-1896</b>	9. AGE (in years last birthday) <b>57</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>		11. BIRTHPLACE (State or foreign country) <b>Ind.</b>	
13. FATHER'S NAME <b>?</b>			14. MOTHER'S MAIDEN NAME <b>?</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Johnson - 102 Albemarle St.</b>	

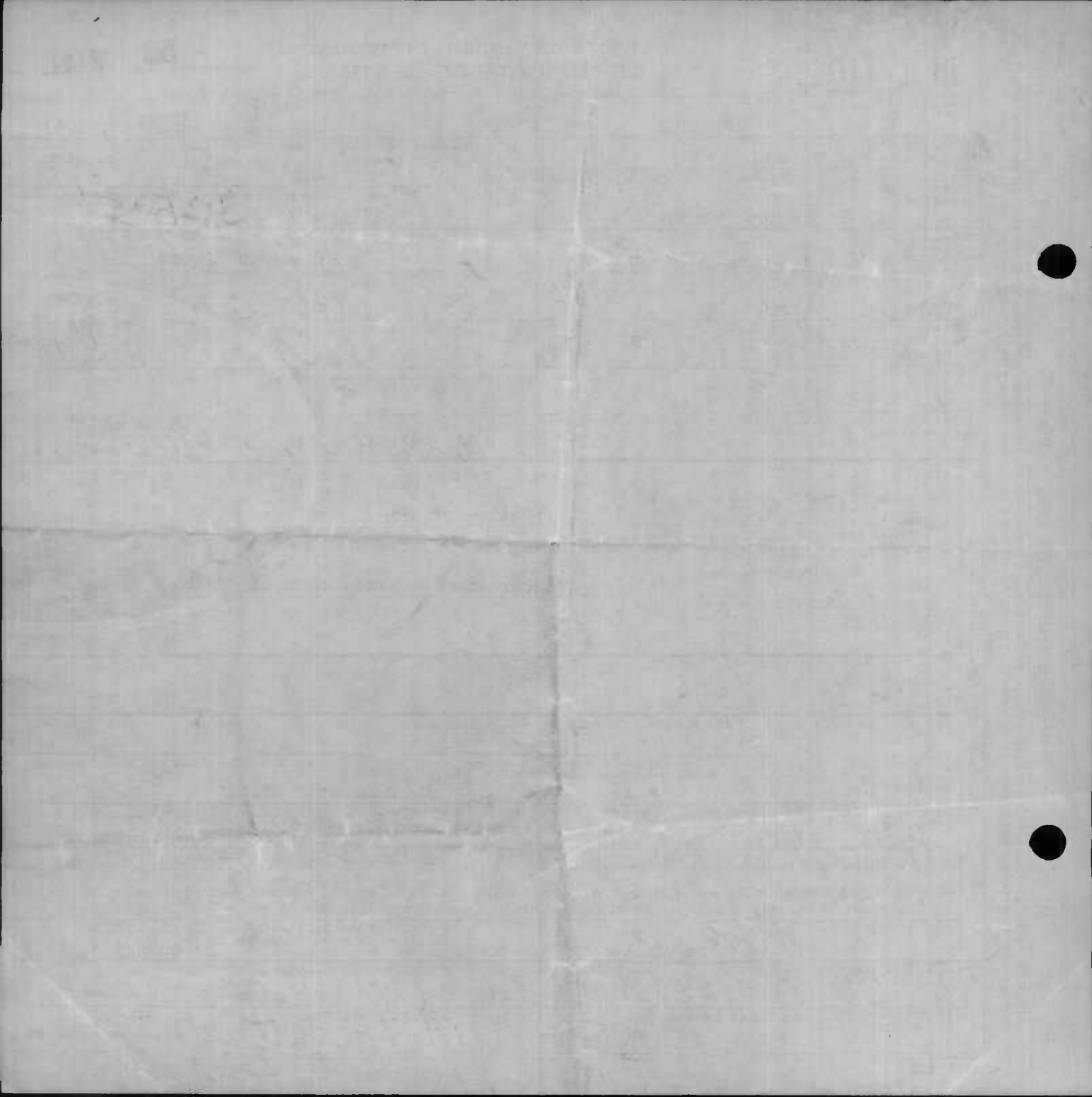
18. <b>E983X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Fracture of skull</b> (A) <b>NO TOX</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES (B) <b>Laceration and contusion of brain</b>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB. <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>102 Albemarle Street</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>8/2/53 12:00 noon m.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Was hit and knocked down stairs</b>	
22. I certify that I took charge of the remains described above, held an <b>Autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>R. Fisher</b>		23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED <b>August 3, 1953</b>	

24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/10/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>Cedar Hill Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>		25. FUNERAL DIRECTOR <b>W. Al Halstead</b>		ADDRESS <b>97024 Almid Hill Ave.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. **53 7111**

BIRTH NO. <b>53 7111</b>		1. NAME OF DECEASED (Type or Print) <b>William Michael Wartman</b>		2. DATE OF DEATH <b>8-5-53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>26-02</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>		D. STREET ADDRESS (If rural, give location) <b>4803 Althea Ave. -6</b>		E. Yrs. Mos. Days	
c. Length of stay in Baltimore <b>Life</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Jan. 18, 1916</b>		9. AGE (In years last birthday) <b>37</b> If Under 1 Year Months Days If Under 24 Hours Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONTRACTOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>OWN BUSINESS</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>		13. FATHER'S NAME <b>HARRY WARTMAN</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Celaslik</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-07-4555</b>		17. INFORMANT ADDRESS <b>B. C. K. Records, 4940 Eastern Ave.</b>	
18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cerebro Vascular Accident</b> DUE TO <b>Hypertensive Cardiac Vascular Disease.</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>7</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <b>Aug. 5, 1953</b> , to <b>Aug 5, 1953</b> 19__, that I last saw the deceased alive on <b>Aug. 5, 19 53</b> , and that death occurred at <b>5.50PM.</b> , from the causes and on the date stated above.		23A. SIGNATURE <b>H. J. Williams, M. D.</b>	
23B. ADDRESS <b>4940 Eastern Ave.</b>		23C. DATE SIGNED <b>8-6-53</b>		24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
24B. DATE <b>AUG 10 1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART</b>		24D. LOCATION (City, town, or county) (State) <b>MARY VERMILAN HILL RD</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 7 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>		25. FUNERAL DIRECTOR ADDRESS <b>STEPHEN J. FIALKOWSKI INC</b>	
VS 150		29024 Marie Fialkowski 10008 Kenwood Ave			

RECEIVED

10

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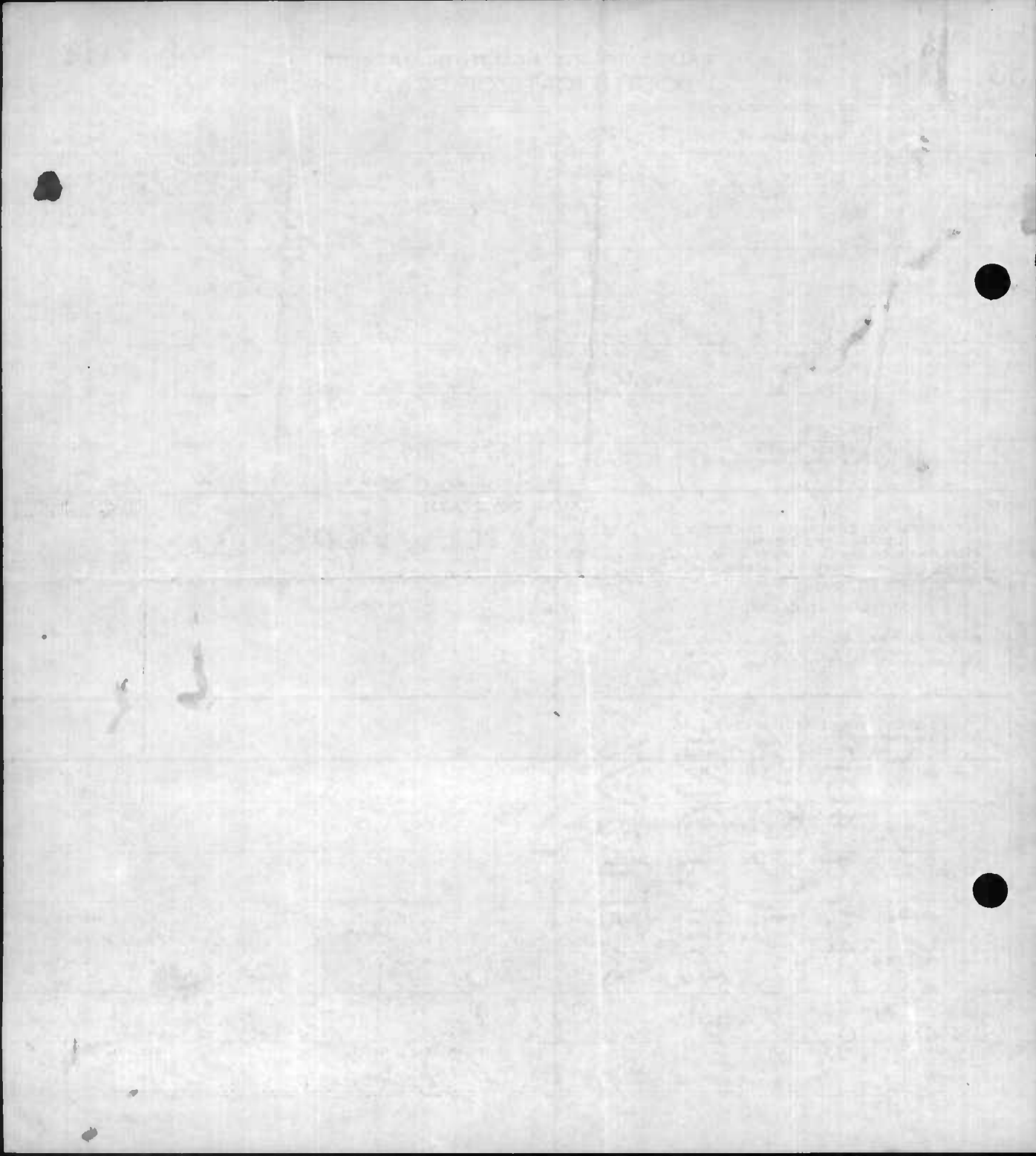
H-610

53 7112

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7112  
Registered No. /

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Joshua Harner</i>		2. DATE OF DEATH <i>8-5-53</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>27 N. Carey St</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> COUNTY <i>Preston</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 11-04</i>			
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <i>322 W. Preston St</i>			
5. SEX <i>M.</i>	6. COLOR OR RACE <i>Col</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Aug. 17, 1879</i>		9. AGE (In years last birthday) <i>73</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Industry</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>James Gault 322 W. Preston St</i>	
18. <i>422.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cardio Vascular</i>		CAUSE OF DEATH (A) <i>Dis ease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>?</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>19</i> to <i>19</i> , that I last saw the deceased alive on <i>1015 am</i> , 19 <i>53</i> , and that death occurred at <i>1015 am</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Frank Johnson</i>		23B. ADDRESS <i>403 Med art B</i>		23C. DATE SIGNED <i>8-5-53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/8/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt Auburn</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>		25. FUNERAL DIRECTOR <i>Charles A. Rice</i>		ADDRESS <i>6614 Barre St</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 7 1953</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>			
VS 150 <i>1353</i>		97099			

MEDICAL CERTIFICATION





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. **53 7113**

BIRTH NO. **53-16210**

1. NAME OF DECEASED

(Type or Print)

**Baby Boy- Fauntleroy- Audrey**

2. DATE  
OF  
DEATH

**8-4-53**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION **Baltimore City Hospitals**  
**4940 Eastern Ave.**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

**Md.**

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

**Baltimore**

**23-01**

D. STREET ADDRESS (If rural, give location)

**124 West West St.-30**

c. Length of stay in Baltimore

**24 days**

Yrs.  
Mos.  
Days

5. SEX

**Male**

6. COLOR OR RACE

**Negro**

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

**Single**

8. DATE OF BIRTH

**July 12, 53**

9. AGE (in years

last birthday)

If Under 1 Year

Months

**24**

If Under 24 Hours

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Md.**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**James Lewis**

14. MOTHER'S MAIDEN NAME

**Audrey Fauntleroy**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

**B. C. H. Records, 4940 Eastern Ave.**

18. **763.5**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Lobar Pneumonia**

DUE TO

ANTECEDENT CAUSES

(B) **Prematurity**

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **July 12**, 19 **53** to **Aug. 4**, 19 **53** that I last saw the deceased alive on **Aug 4**, 19 **53** and that death occurred at **11.45am** from the causes and on the date stated above.

23A. SIGNATURE

**H. John Lee**

M. D.

23B. ADDRESS

**4940 Eastern Ave.**

23C. DATE SIGNED

**8-6-53**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Cremated**

24B. DATE

**8-5-53 @ 9am**

24C. NAME OF CEMETERY OR CREMATORY

**B. C. H. Crematory**

24D. LOCATION (City, town, or county)

**4940 Eastern Ave.**

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**AUG 7 1953**

**H. John Lee**

**7 Huntington Williams, Md.**

NEW YORK - NEW YORK

NEW YORK - NEW YORK

NEW YORK - NEW YORK

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NEW YORK - NEW YORK

NEW YORK - NEW YORK

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB -165384

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7114

Registered No.

BIRTH NO. 53 7114

1. NAME OF DECEASED  
(Type or Print)

Harry A. Jones

2. DATE  
OF  
DEATH

8-2-1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTEBaltimore City Hospitals  
4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3604 Mohawk Ave. zone 7

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months Days If Under 24 Hours Hours Min.

?

88?

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Oliver Bell (Bett)

14. MOTHER'S MAIDEN NAME

Mary Jane

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL SECURITY NO.

17. INFORMANT Baltimore City Hospitals  
Records: 4940 Eastern Ave.

18.

491X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-28-1952, to 8-2-1953 that I last saw the deceased alive on 8-2-1953 and that death occurred at 3:20A.M., from the causes and on the date stated above.

23A. SIGNATURE

H. J. Jones M.D.

23B. ADDRESS

4940 Eastern Ave., Baltimore, Md.

23C. DATE SIGNED

8-2-1953

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 7, 1953

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

John O. Mitchell &amp; Sons, Inc.

VS 150

1900 EUTAW PLACE

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R-000  
53 7115BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

53 7115

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

George Hart Rowe

2. DATE  
OF  
DEATH

Aug 6, 1953.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

Union Memorial Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland Baltimore

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Catonsville Maryland

D. STREET ADDRESS (If rural, give location)

8 OAK GROVE AVE. 5352

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

M

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR

Secty. Stevens Industry

Publishing Co.

13. FATHER'S NAME

Harry M. Rowe.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL

SECURITY NO.

8. DATE OF BIRTH

Dec. 15, 1882 70 71

9. AGE (In years last birthday)

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

11. BIRTHPLACE (State or foreign country)

Pennsylvania.

12. CITIZEN OF

WHAT COUNTRY?

US.

14. MOTHER'S MAIDEN NAME

Kate Postley.

17. INFORMANT

ADDRESS CATONS,

Mrs. ELEANOR S. Rowe 8 Oakgrove Ave.

18. 420.1 and 177X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

myocardial infarction

3 days

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Carcinoma of the Prostate

?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT

NOT WHILE

WORK ☐AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 27, 1953, to Aug 6, 1953, that I last saw the deceased alive on Aug 6, 1953, and that death occurred at 9:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

CREMATION

Aug. 8, 1953

GREENMOUNT

BALTIMORE,

Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 7 1953

H. H. Willoughby, John O. Mitchell Sns 1900 Eutaw Pl

STATE OF TEXAS  
COUNTY OF DALLAS

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of said County, at Dallas, Texas, this 1st day of January, 1901.

\_\_\_\_\_  
County Clerk



M-2-204

## BALTIMORE CITY HEALTH DEPARTMENT

53 7116

53 7116 53-09278 CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED  
(Type or Print)

McCAUSLAND, Martha PIERSON

2. DATE  
OF  
DEATH

8/5/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore Towson 5355

D. STREET ADDRESS (If rural, give location)

605 W Yoppa Road, MD

C. Length of stay in Baltimore

3 1/2 - Mos.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

4/21/53

9. AGE (In years last birthday)

10. Under 1 Year Months: Days: 3 15

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Patterson McCausland

14. MOTHER'S MAIDEN NAME

HELEN R. ZIMMERMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

Dr. CHARLES P. McCausland Towson, Md

18. 756.2 I

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) No aras mus

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Malrotation of colon and Adhesions

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

5/29/1953

19B. MAJOR FINDINGS OF OPERATION

Malrotation of colon

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/28/1953, to 8/5/1953, that I last saw the deceased alive on 8/5/1953, and that death occurred at 2:33 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Tabacan Espinoza

M. D.

23B. ADDRESS

Union Memorial Hospital

23C. DATE SIGNED

8/5/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 7, 1953

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn

24D. LOCATION (City, town, or county)

Woodlawn

(State)

Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 7 1953

Huntington Williams, Md.

John O. Mitchell &amp; Sons 1900 Eutaw Pl.

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53 7117

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

53 7117  
BIRTH NO. 53-18163

1. NAME OF DECEASED (Type or Print) <b>BABY GIRL DAVIS</b>		2. DATE OF DEATH <b>8-6-53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>A.A.</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Bon Secours Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Linthicum Heights</b>	
D. STREET ADDRESS (If rural, give location) <b>Woodlawn Rd 5200</b>		E. LENGTH OF STAY IN BALTIMORE Yrs. _____ Mos. _____ Days _____	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>S</b>	8. DATE OF BIRTH <b>8-5-53</b>
9. AGE (In years last birthday) _____	10. UNDER 1 Year Months: _____ Days: _____	11. UNDER 24 Hours Hours: _____ Min: _____	12. CITIZEN OF WHAT COUNTRY? <b>MD</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>0</b>	
13. FATHER'S NAME <b>DONALD DAVIS</b>		14. MOTHER'S MAIDEN NAME <b>PAULINE MARK GARRISON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. _____	
17. FAMILIAL ADDRESS <b>FAMILY HOME</b>		18. CAUSE OF DEATH	

18. 761.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Anoxia</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Premature separation of placenta</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 8-5, 1953, to 8-6, 1953; that I last saw the deceased alive on 8-6, 1953, and that death occurred at 9 A m., from the causes and on the date stated above.

23A. SIGNATURE <b>William G. Williams M. O.</b>		23B. ADDRESS <b>Bon Secours Hosp</b>		23C. DATE SIGNED <b>8-6-53</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>B.</b>	24B. DATE <b>8-7-53</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	24D. LOCATION (City, town, or county) (State) <b>Baels.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 7 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>		25. FUNERAL DIRECTOR <b>130 E. Fort Ave.</b>

MEDICAL CERTIFICATION

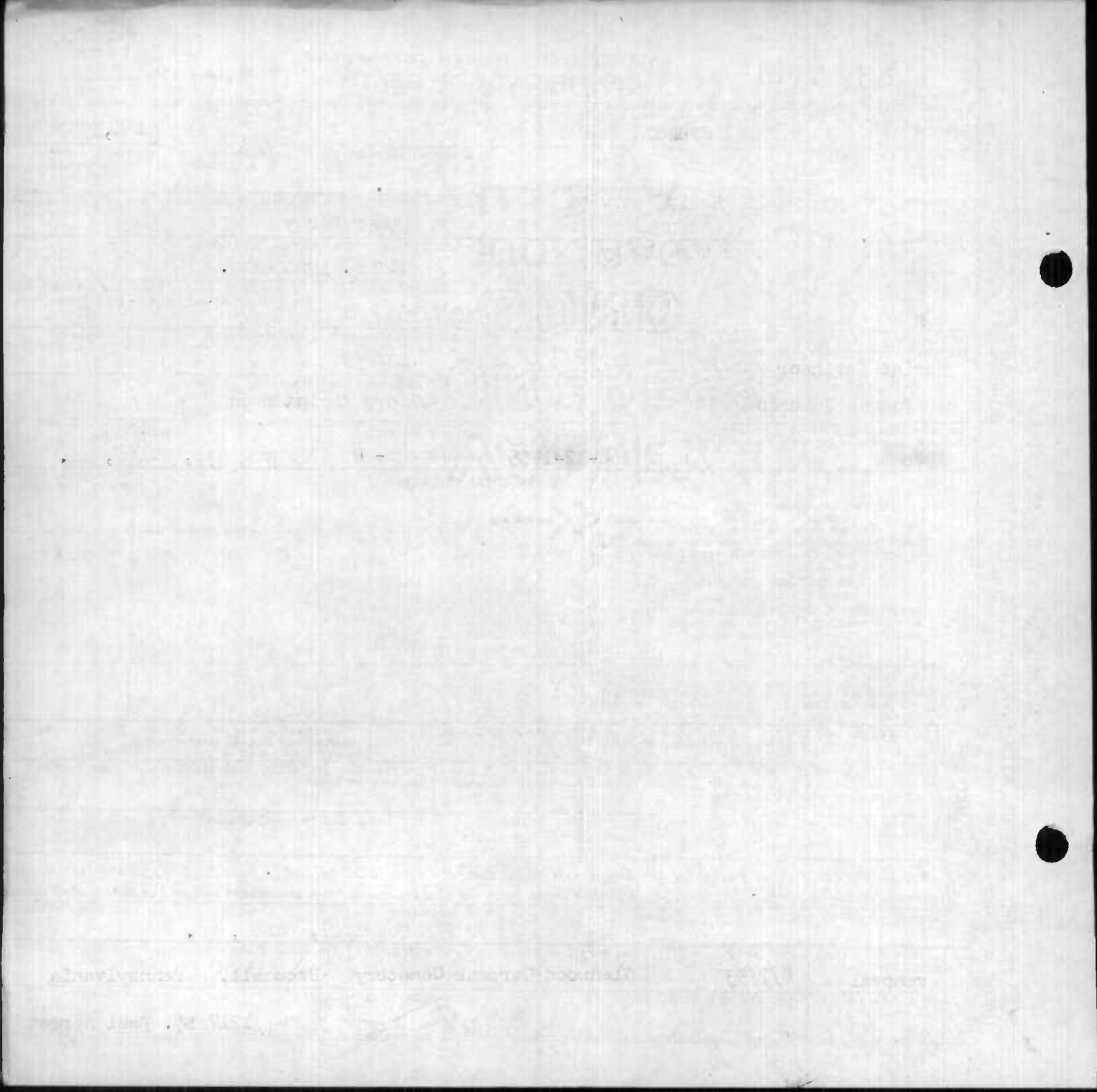
STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

1921

1921

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

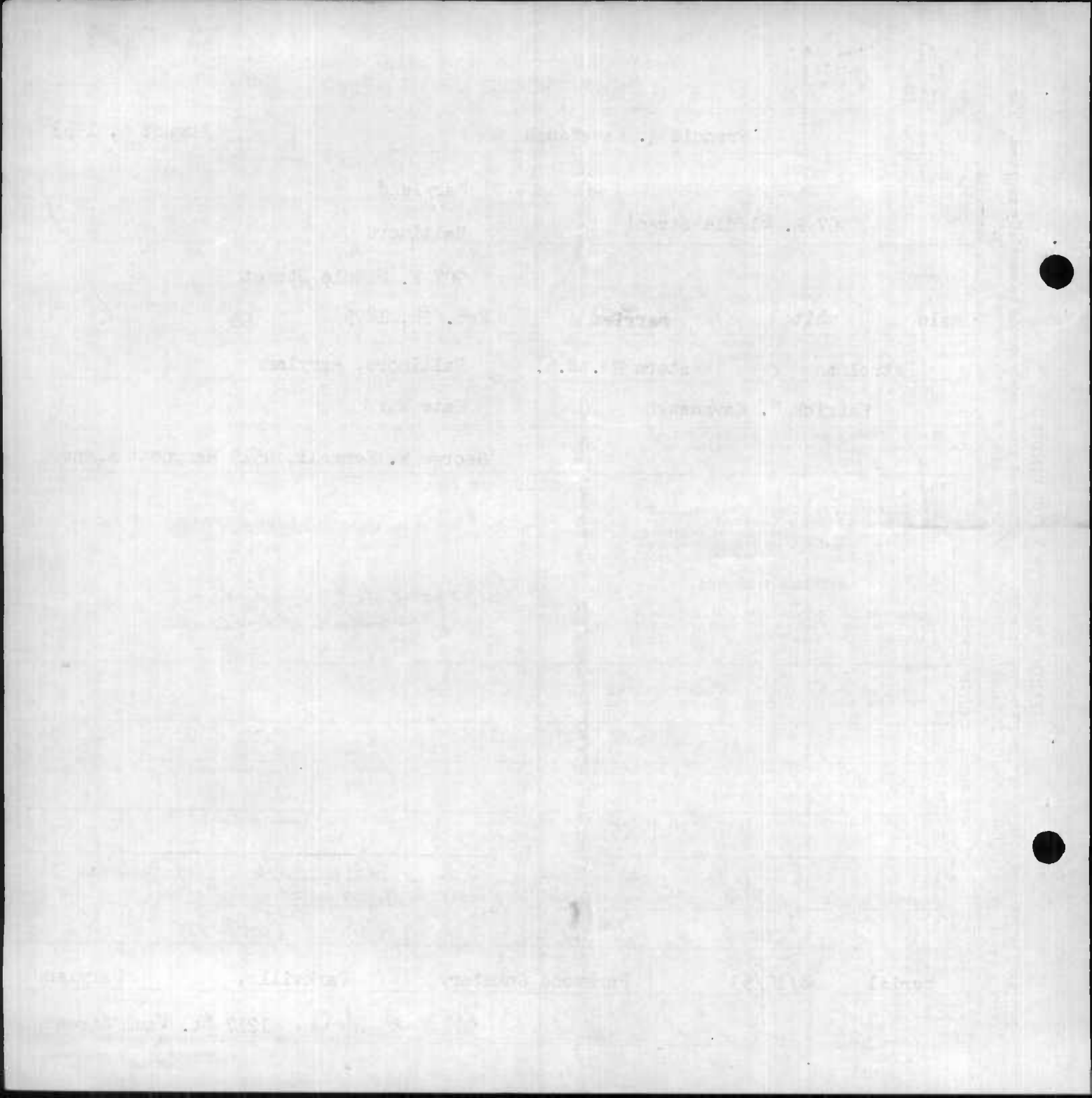
J-525 53 7118		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X 53 7118 Registered No.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JOHN PETER JOHNSON</b>		2. DATE OF DEATH <b>August 6, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Pa.</b> B. COUNTY <b>V-35</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Upper Darby</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>US Public Health Service Hospital Wyman Pk. drive &amp; 31st street less than 1 day</b>		D. STREET ADDRESS (If rural, give location) <b>212 S. Lynn Blvd.</b>		Yrs. Mos. Days	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>2/8/96</b>	9. AGE (In years last birthday) <b>56 57</b>	If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Marine Engineer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Seafarer</b>		11. BIRTHPLACE (State or foreign country) <b>Norway</b>	
12. CITIZEN OF WHAT COUNTRY? <b>?</b>		13. FATHER'S NAME <b>Joanes Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Valborg Christensen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>168-12-1965</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>331x and 260x</b>		CAUSE OF DEATH <b>Cerebral Vascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT. <b>Diabetic Coma</b>		(A) DUE TO		(B) DUE TO	
(C) DUE TO					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <b>August 5, 1953</b> to <b>Aug. 6, 1953</b> that I last saw the deceased alive on <b>Aug. 6, 1953</b> , and that death occurred at <b>2:40A. m.</b> , from the causes and on the date stated above.		23A. SIGNATURE <b>C. M. M. M.</b>	
23B. ADDRESS <b>US PHS Hospital, Balto, Md.</b>		23C. DATE SIGNED		24A. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	
24B. DATE <b>8/7/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Glenwood Gardens Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Broomall, Pennsylvania</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 7 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington W. Williams, M.D.</b>		25. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook, Inc., 1217 St. Paul Street</b>	
VS 150		24055			





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

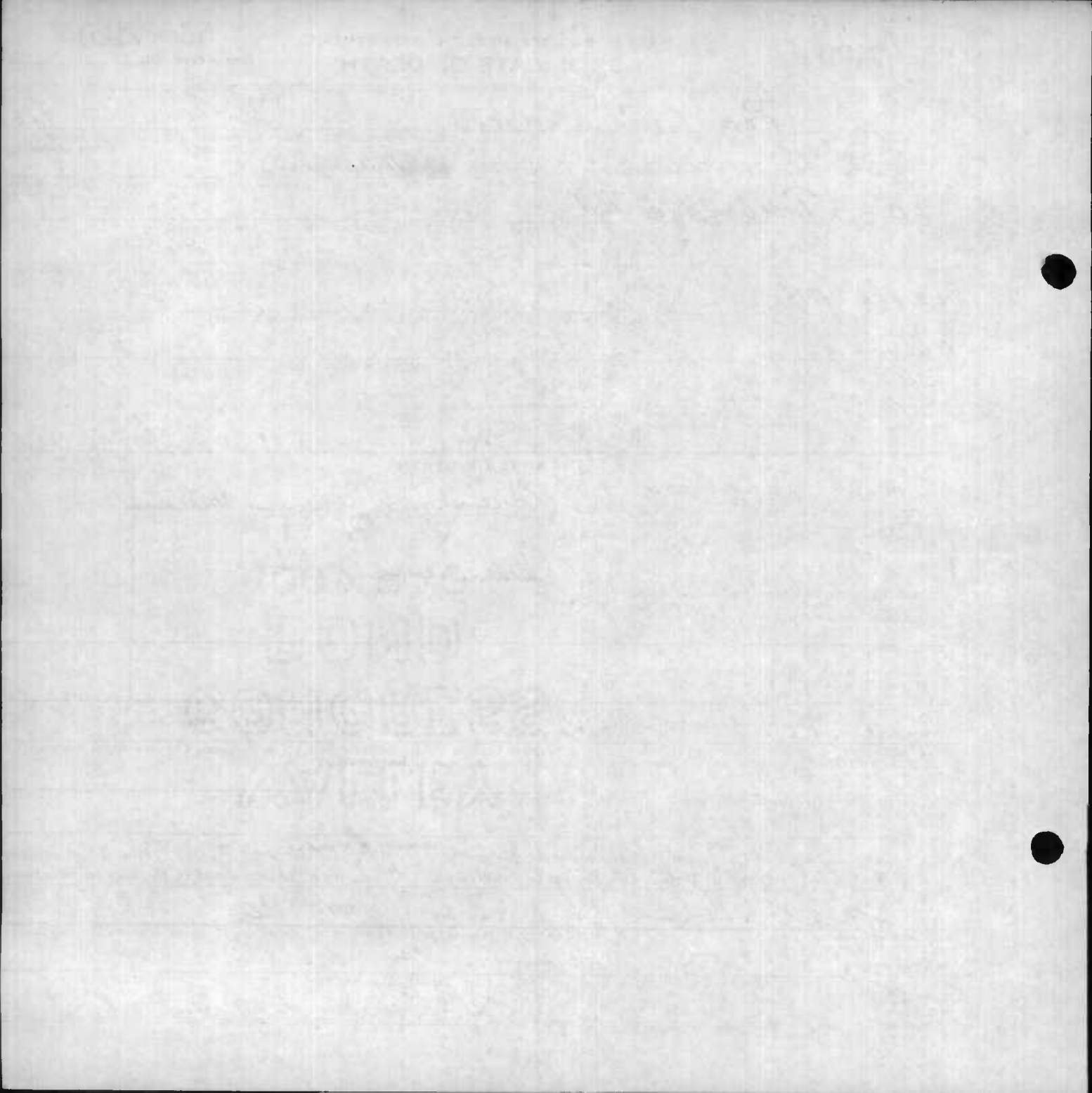
BIRTH NO.				Baltimore City Health Department Certificate of Death		Registered No. 53 7119	
1. NAME OF DECEASED (Type or Print) <b>Francis A. Kavanaugh</b>				2. DATE OF DEATH <b>August 6, 1953</b>			
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>907 E. Biddle Street</b>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>10-01</b>			
c. Length of stay in Baltimore Yrs. Mos. Days				O. STREET ADDRESS (If rural, give location) <b>907 E. Biddle Street</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Feb. 28, 1895</b>		9. AGE (In years last birthday) <b>58</b>	10. Under 1 Year Months: Days	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Patrolman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Western Md. R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Patrick F. Kavanaugh</b>				14. MOTHER'S MAIDEN NAME <b>Kate Ward</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>George W. Kendall, 4519 Hampnett Avenue</b>			
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> DUE TO <b>Anteroseptal Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Ischemic Heart Disease</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>?</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>8/2</b> , 19 <b>53</b> , to <b>8/6</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>8/5</b> , 19 <b>53</b> , and that death occurred at <b>2 A.</b> m., from the causes and on the date stated above.							
23A. SIGNATURE <b>Joseph S. Blum</b> M.D.				23B. ADDRESS <b>1110 N. Calver St</b>		23C. DATE SIGNED <b>8/6/53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>8/10/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Parkville, Maryland</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 7 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		25. FUNERAL DIRECTOR ADDRESS <b>Stm. Cook, Inc., 1217 St. Paul Street</b>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

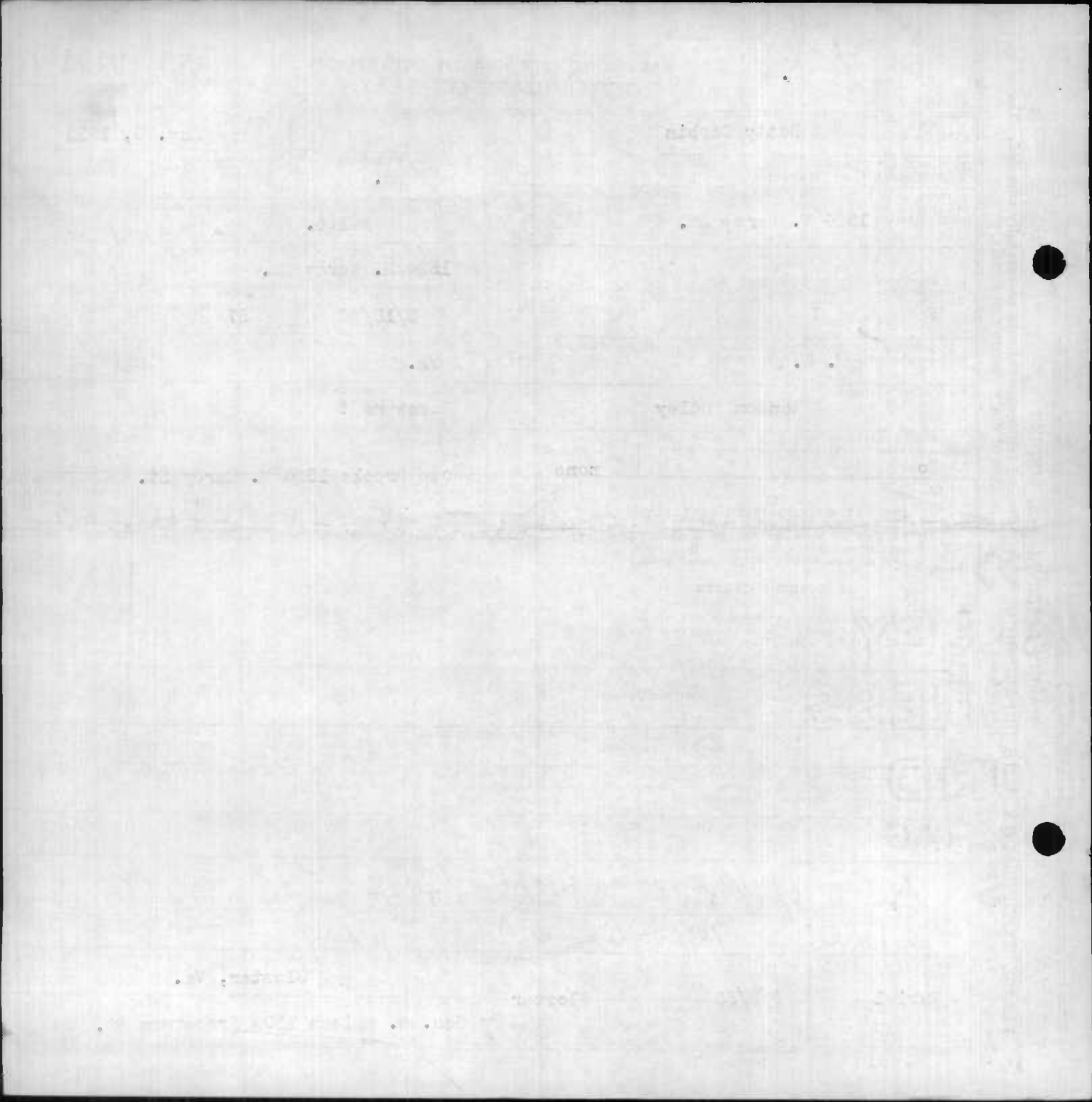
53 7120		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		53 7120 Registered No.	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>Pearl V. Lantz</i>			2. DATE OF DEATH <i>August 7-1953</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1</i>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>1030 Tunbridge Rd</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>27-48</i>		
C. Length of stay in Baltimore <i>3 yrs</i>			D. STREET ADDRESS (If rural, give location) <i>1030 Tunbridge Rd</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>widow</i>	8. DATE OF BIRTH <i>Dec 30, 1900</i>	9. AGE (In years last birthday) <i>52</i>	10. Under 1 Year Months: <i>8</i> Days: <i>7</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>clock</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>clock making</i>		
11. BIRTHPLACE (State or foreign country) <i>Pa.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Clifford Lantz</i>			14. MOTHER'S MAIDEN NAME <i>Mary Houser</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Mrs J. Turner</i>			ADDRESS <i>1030 Tunbridge Rd</i>		
18. <i>153X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Generalized Abdominal metastases</i>			CAUSE OF DEATH <i>Carcinoma of Colon</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>April 1, 1953</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Diagnosis of tumor</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>January 10, 1953</i> to <i>August 7, 1953</i> that I last saw the deceased alive on <i>August 6, 1953</i> and that death occurred at <i>5 A</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Wesley S. Carr</i>		23B. ADDRESS <i>6201 York Rd</i>		23C. DATE SIGNED <i>8/7/53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>8/7/53</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cem</i>	
24D. LOCATION (City, town, or county) (State) <i>The Vestments, Pa.</i>		25. FUNERAL DIRECTOR <i>Wm. Cook Inc.</i>		ADDRESS <i>1217 St. Paul St.</i>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>Huntington Hill</i>		VS 150	

3906L



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. <u>53 7121</u>	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <u>Betty Corbin</u>				2. DATE OF DEATH <u>Aug. 6, 1953</u>	
3. PLACE OF DEATH: A. <u>Baltimore City, Maryland</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY	
8. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>1524 N. Carey St.</u>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Balto.</u>	
c. Length of stay in Baltimore ? Yrs. Mos. Days				D. STREET ADDRESS (If rural, give location) <u>1524 N. Carey St.</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>	8. DATE OF BIRTH <u>3/18/96</u>	9. AGE (In years last birthday) <u>57</u>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>118 W.</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Va.</u>
13. FATHER'S NAME <u>Ransom Dudley</u>			14. MOTHER'S MAIDEN NAME <u>Roseanna ?</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT ADDRESS <u>Rose Brooks 1524 N. Carey St.</u>	
18. <u>420.0</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <u>Intense chronic heart disease ?</u> DUE TO ANTECEDENT CAUSES (B) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3/10/51</u> , 19 <u>51</u> , to <u>8/4/53</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>8/5/53</u> , 19 <u>53</u> , and that death occurred at <u>230 A.</u> m., from the causes and on the date stated above.					
23A. SIGNATURE <u>William M. Danner</u>		23B. ADDRESS <u>1555 George St.</u>		23C. DATE SIGNED	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/8/53</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Gloster</u>	
24D. LOCATION (City, town, or county) (State) <u>Gloster, Va.</u>		25. FUNERAL DIRECTOR ADDRESS <u>Geo. G. Kelson 1303 Presstman St.</u>			
DATE RECEIVED BY LOCAL REGISTRAR <u>187 1953</u>		REGISTRAR'S SIGNATURE <u>Huntington Williams, M.D.</u>			





15-625  
53 7122

53 7122

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <b>RICHARD EUGENE KIRCHNER</b>		2. DATE OF DEATH <b>8/6/53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b>			
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSP.</b>		C. CITY OR TOWN <b>BALTIMORE 27-01</b>			
6. Length of stay in Baltimore <b>35</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>3207 TYNDALE AVE.</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>		8. DATE OF BIRTH <b>8/5/81</b>	9. AGE (In years, birthday) <b>72</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRAVELING SALES</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>	
13. FATHER'S NAME <b>HERMAN KIRCHNER</b>		14. MOTHER'S MAIDEN NAME <b>?</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT <b>SON - R.E. KIRCHNER</b> ADDRESS <b>SAME</b>	
18. <b>331X</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>PROBABLE PULMONARY EDEMA</b> DUE TO <b>CEREBRAL HEMORRHAGE</b> DUE TO <b>CEREBRAL HEMORRHAGE</b> DUE TO <b>CEREBRAL HEMORRHAGE</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION _____		19B. MAJOR FINDINGS OF OPERATION _____			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) INJURY _____		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <b>8/5</b> , 19 <b>53</b> to <b>8/6</b> , 19 <b>53</b> that I last saw the deceased alive on <b>8/6</b> , 19 <b>53</b> and that death occurred at <b>4:10</b> P.m., from the causes and on the date stated above.					
23A. SIGNATURE <b>Loyle E. Spencer Jr.</b>		M. D. <b>J. M. H.</b>		23B. ADDRESS _____	
23C. DATE SIGNED <b>8/6/53</b>					
24A. BURIAL, CREMATION, REMOVAL (Specify) _____		24B. DATE <b>8/10/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Woodland Memorial Park</b>	
24D. LOCATION (City, town, or county) <b>Taylor and -</b>		(State) _____			
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 7 1953</b>		REGISTRAR'S SIGNATURE <b>H. E. T. W. H. 3rd</b>		25. FUNERAL DIRECTOR <b>J. C. Beck</b> ADDRESS <b>5305 Norfolk Rd.</b>	

49099

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
OFFICE OF THE COMMISSIONER  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Birth		6. Usual Residence		7. Cause of Death		8. Manner of Death	
9. Name of Physician		10. Name of Undertaker		11. Name of Burial Place		12. Name of Funeral Home	
13. Name of Hospital		14. Name of Doctor		15. Name of Nurse		16. Name of Embalmer	
17. Name of Coroner		18. Name of Jury		19. Name of Witness		20. Name of Registrar	
21. Name of Burial Place		22. Name of Funeral Home		23. Name of Undertaker		24. Name of Physician	
25. Name of Hospital		26. Name of Doctor		27. Name of Nurse		28. Name of Embalmer	
29. Name of Coroner		30. Name of Jury		31. Name of Witness		32. Name of Registrar	
33. Name of Burial Place		34. Name of Funeral Home		35. Name of Undertaker		36. Name of Physician	
37. Name of Hospital		38. Name of Doctor		39. Name of Nurse		40. Name of Embalmer	
41. Name of Coroner		42. Name of Jury		43. Name of Witness		44. Name of Registrar	
45. Name of Burial Place		46. Name of Funeral Home		47. Name of Undertaker		48. Name of Physician	
49. Name of Hospital		50. Name of Doctor		51. Name of Nurse		52. Name of Embalmer	
53. Name of Coroner		54. Name of Jury		55. Name of Witness		56. Name of Registrar	
57. Name of Burial Place		58. Name of Funeral Home		59. Name of Undertaker		60. Name of Physician	
61. Name of Hospital		62. Name of Doctor		63. Name of Nurse		64. Name of Embalmer	
65. Name of Coroner		66. Name of Jury		67. Name of Witness		68. Name of Registrar	
69. Name of Burial Place		70. Name of Funeral Home		71. Name of Undertaker		72. Name of Physician	
73. Name of Hospital		74. Name of Doctor		75. Name of Nurse		76. Name of Embalmer	
77. Name of Coroner		78. Name of Jury		79. Name of Witness		80. Name of Registrar	
81. Name of Burial Place		82. Name of Funeral Home		83. Name of Undertaker		84. Name of Physician	
85. Name of Hospital		86. Name of Doctor		87. Name of Nurse		88. Name of Embalmer	
89. Name of Coroner		90. Name of Jury		91. Name of Witness		92. Name of Registrar	
93. Name of Burial Place		94. Name of Funeral Home		95. Name of Undertaker		96. Name of Physician	
97. Name of Hospital		98. Name of Doctor		99. Name of Nurse		100. Name of Embalmer	
101. Name of Coroner		102. Name of Jury		103. Name of Witness		104. Name of Registrar	
105. Name of Burial Place		106. Name of Funeral Home		107. Name of Undertaker		108. Name of Physician	
109. Name of Hospital		110. Name of Doctor		111. Name of Nurse		112. Name of Embalmer	
113. Name of Coroner		114. Name of Jury		115. Name of Witness		116. Name of Registrar	
117. Name of Burial Place		118. Name of Funeral Home		119. Name of Undertaker		120. Name of Physician	
121. Name of Hospital		122. Name of Doctor		123. Name of Nurse		124. Name of Embalmer	
125. Name of Coroner		126. Name of Jury		127. Name of Witness		128. Name of Registrar	
129. Name of Burial Place		130. Name of Funeral Home		131. Name of Undertaker		132. Name of Physician	
133. Name of Hospital		134. Name of Doctor		135. Name of Nurse		136. Name of Embalmer	
137. Name of Coroner		138. Name of Jury		139. Name of Witness		140. Name of Registrar	
141. Name of Burial Place		142. Name of Funeral Home		143. Name of Undertaker		144. Name of Physician	
145. Name of Hospital		146. Name of Doctor		147. Name of Nurse		148. Name of Embalmer	
149. Name of Coroner		150. Name of Jury		151. Name of Witness		152. Name of Registrar	
153. Name of Burial Place		154. Name of Funeral Home		155. Name of Undertaker		156. Name of Physician	
157. Name of Hospital		158. Name of Doctor		159. Name of Nurse		160. Name of Embalmer	
161. Name of Coroner		162. Name of Jury		163. Name of Witness		164. Name of Registrar	
165. Name of Burial Place		166. Name of Funeral Home		167. Name of Undertaker		168. Name of Physician	
169. Name of Hospital		170. Name of Doctor		171. Name of Nurse		172. Name of Embalmer	
173. Name of Coroner		174. Name of Jury		175. Name of Witness		176. Name of Registrar	
177. Name of Burial Place		178. Name of Funeral Home		179. Name of Undertaker		180. Name of Physician	
181. Name of Hospital		182. Name of Doctor		183. Name of Nurse		184. Name of Embalmer	
185. Name of Coroner		186. Name of Jury		187. Name of Witness		188. Name of Registrar	
189. Name of Burial Place		190. Name of Funeral Home		191. Name of Undertaker		192. Name of Physician	
193. Name of Hospital		194. Name of Doctor		195. Name of Nurse		196. Name of Embalmer	
197. Name of Coroner		198. Name of Jury		199. Name of Witness		200. Name of Registrar	
201. Name of Burial Place		202. Name of Funeral Home		203. Name of Undertaker		204. Name of Physician	
205. Name of Hospital		206. Name of Doctor		207. Name of Nurse		208. Name of Embalmer	
209. Name of Coroner		210. Name of Jury		211. Name of Witness		212. Name of Registrar	
213. Name of Burial Place		214. Name of Funeral Home		215. Name of Undertaker		216. Name of Physician	
217. Name of Hospital		218. Name of Doctor		219. Name of Nurse		220. Name of Embalmer	
221. Name of Coroner		222. Name of Jury		223. Name of Witness		224. Name of Registrar	
225. Name of Burial Place		226. Name of Funeral Home		227. Name of Undertaker		228. Name of Physician	
229. Name of Hospital		230. Name of Doctor		231. Name of Nurse		232. Name of Embalmer	
233. Name of Coroner		234. Name of Jury		235. Name of Witness		236. Name of Registrar	
237. Name of Burial Place		238. Name of Funeral Home		239. Name of Undertaker		240. Name of Physician	
241. Name of Hospital		242. Name of Doctor		243. Name of Nurse		244. Name of Embalmer	
245. Name of Coroner		246. Name of Jury		247. Name of Witness		248. Name of Registrar	
249. Name of Burial Place		250. Name of Funeral Home		251. Name of Undertaker		252. Name of Physician	
253. Name of Hospital		254. Name of Doctor		255. Name of Nurse		256. Name of Embalmer	
257. Name of Coroner		258. Name of Jury		259. Name of Witness		260. Name of Registrar	
261. Name of Burial Place		262. Name of Funeral Home		263. Name of Undertaker		264. Name of Physician	
265. Name of Hospital		266. Name of Doctor		267. Name of Nurse		268. Name of Embalmer	
269. Name of Coroner		270. Name of Jury		271. Name of Witness		272. Name of Registrar	
273. Name of Burial Place		274. Name of Funeral Home		275. Name of Undertaker		276. Name of Physician	
277. Name of Hospital		278. Name of Doctor		279. Name of Nurse		280. Name of Embalmer	
281. Name of Coroner		282. Name of Jury		283. Name of Witness		284. Name of Registrar	
285. Name of Burial Place		286. Name of Funeral Home		287. Name of Undertaker		288. Name of Physician	
289. Name of Hospital		290. Name of Doctor		291. Name of Nurse		292. Name of Embalmer	
293. Name of Coroner		294. Name of Jury		295. Name of Witness		296. Name of Registrar	
297. Name of Burial Place		298. Name of Funeral Home		299. Name of Undertaker		300. Name of Physician	
301. Name of Hospital		302. Name of Doctor		303. Name of Nurse		304. Name of Embalmer	
305. Name of Coroner		306. Name of Jury		307. Name of Witness		308. Name of Registrar	
309. Name of Burial Place		310. Name of Funeral Home		311. Name of Undertaker		312. Name of Physician	
313. Name of Hospital		314. Name of Doctor		315. Name of Nurse		316. Name of Embalmer	
317. Name of Coroner		318. Name of Jury		319. Name of Witness		320. Name of Registrar	
321. Name of Burial Place		322. Name of Funeral Home		323. Name of Undertaker		324. Name of Physician	
325. Name of Hospital		326. Name of Doctor		327. Name of Nurse		328. Name of Embalmer	
329. Name of Coroner		330. Name of Jury		331. Name of Witness		332. Name of Registrar	
333. Name of Burial Place		334. Name of Funeral Home		335. Name of Undertaker		336. Name of Physician	
337. Name of Hospital		338. Name of Doctor		339. Name of Nurse		340. Name of Embalmer	
341. Name of Coroner		342. Name of Jury		343. Name of Witness		344. Name of Registrar	
345. Name of Burial Place		346. Name of Funeral Home		347. Name of Undertaker		348. Name of Physician	
349. Name of Hospital		350. Name of Doctor		351. Name of Nurse		352. Name of Embalmer	
353. Name of Coroner		354. Name of Jury		355. Name of Witness		356. Name of Registrar	
357. Name of Burial Place		358. Name of Funeral Home		359. Name of Undertaker		360. Name of Physician	
361. Name of Hospital		362. Name of Doctor		363. Name of Nurse		364. Name of Embalmer	
365. Name of Coroner		366. Name of Jury		367. Name of Witness		368. Name of Registrar	
369. Name of Burial Place		370. Name of Funeral Home		371. Name of Undertaker		372. Name of Physician	
373. Name of Hospital		374. Name of Doctor		375. Name of Nurse		376. Name of Embalmer	
377. Name of Coroner		378. Name of Jury		379. Name of Witness		380. Name of Registrar	
381. Name of Burial Place		382. Name of Funeral Home		383. Name of Undertaker		384. Name of Physician	
385. Name of Hospital		386. Name of Doctor		387. Name of Nurse		388. Name of Embalmer	
389. Name of Coroner		390. Name of Jury		391. Name of Witness		392. Name of Registrar	
393. Name of Burial Place		394. Name of Funeral Home		395. Name of Undertaker		396. Name of Physician	
397. Name of Hospital		398. Name of Doctor		399. Name of Nurse		400. Name of Embalmer	
401. Name of Coroner		402. Name of Jury		403. Name of Witness		404. Name of Registrar	
405. Name of Burial Place		406. Name of Funeral Home		407. Name of Undertaker		408. Name of Physician	
409. Name of Hospital		410. Name of Doctor		411. Name of Nurse		412. Name of Embalmer	
413. Name of Coroner		414. Name of Jury		415. Name of Witness		416. Name of Registrar	
417. Name of Burial Place		418. Name of Funeral Home		419. Name of Undertaker		420. Name of Physician	
421. Name of Hospital		422. Name of Doctor		423. Name of Nurse		424. Name of Embalmer	
425. Name of Coroner		426. Name of Jury		427. Name of Witness		428. Name of Registrar	
429. Name of Burial Place		430. Name of Funeral Home		431. Name of Undertaker		432. Name of Physician	
433. Name of Hospital		434. Name of Doctor		435. Name of Nurse		436. Name of Embalmer	
437. Name of Coroner		438. Name of Jury		439. Name of Witness		440. Name of Registrar	
441. Name of Burial Place		442. Name of Funeral Home		443. Name of Undertaker		444. Name of Physician	
445. Name of Hospital		446. Name of Doctor		447. Name of Nurse		448. Name of Embalmer	
449. Name of Coroner		450. Name of Jury		451. Name of Witness		452. Name of Registrar	
453. Name of Burial Place		454. Name of Funeral Home		455. Name of Undertaker		456. Name of Physician	
457. Name of Hospital		458. Name of Doctor		459. Name of Nurse		460. Name of Embalmer	
461. Name of Coroner		462. Name of Jury		463. Name of Witness		464. Name of Registrar	
465. Name of Burial Place		466. Name of Funeral Home		467. Name of Undertaker		468. Name of Physician	
469. Name of Hospital		470. Name of Doctor		471. Name of Nurse		472. Name of Embalmer	
473. Name of Coroner		474. Name of Jury		475. Name of Witness		476. Name of Registrar	
477. Name of Burial Place		478. Name of Funeral Home		479. Name of Undertaker		480. Name of Physician	
481. Name of Hospital		482. Name of Doctor		483. Name of Nurse		484. Name of Embalmer	
485. Name of Coroner		486. Name of Jury		487. Name of Witness		488. Name of Registrar	
489. Name of Burial Place		490. Name of Funeral Home		491. Name of Undertaker		492. Name of Physician	
493. Name of Hospital		494. Name of Doctor		495. Name of Nurse		496. Name of Embalmer	
497. Name of Coroner		498. Name of Jury		499. Name of Witness		500. Name of Registrar	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

J-500  
53 7123BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Lewis Ellsworth Soomey

2. DATE  
OF  
DEATH

Aug. 4, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, or institution: residence before admission)

A. STATE Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTE

1218 St. Lafayette Ave. Baltimore 16-01

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1218 St. Lafayette Ave.

c. Length of stay in Baltimore

5. SEX

male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct. 6, 1872

9. AGE (In years, last birthday)

80

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Teacher

10B. KIND OF BUSINESS OR INDUSTRY

Music

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Henry Soomey

14. MOTHER'S MAIDEN NAME

Lydia Ann Stewart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT (Name and address)

Mrs. Florence M. Soomey  
1218 St. Lafayette Ave.

18. 592x

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) .....  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) .....  
DUE TO

(C) .....

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 1953 to Aug 4, 1953, that I last saw the deceased alive on Aug 4, 1953, and that death occurred at 4:18 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Stanford P. Brunsden

23B. ADDRESS

2309 Druid Hill Ave

23C. DATE SIGNED

8-7-53

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 8, 1953

24C. NAME OF CEMETERY OR CREMATORY

Cathartes Mem. Pk.

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

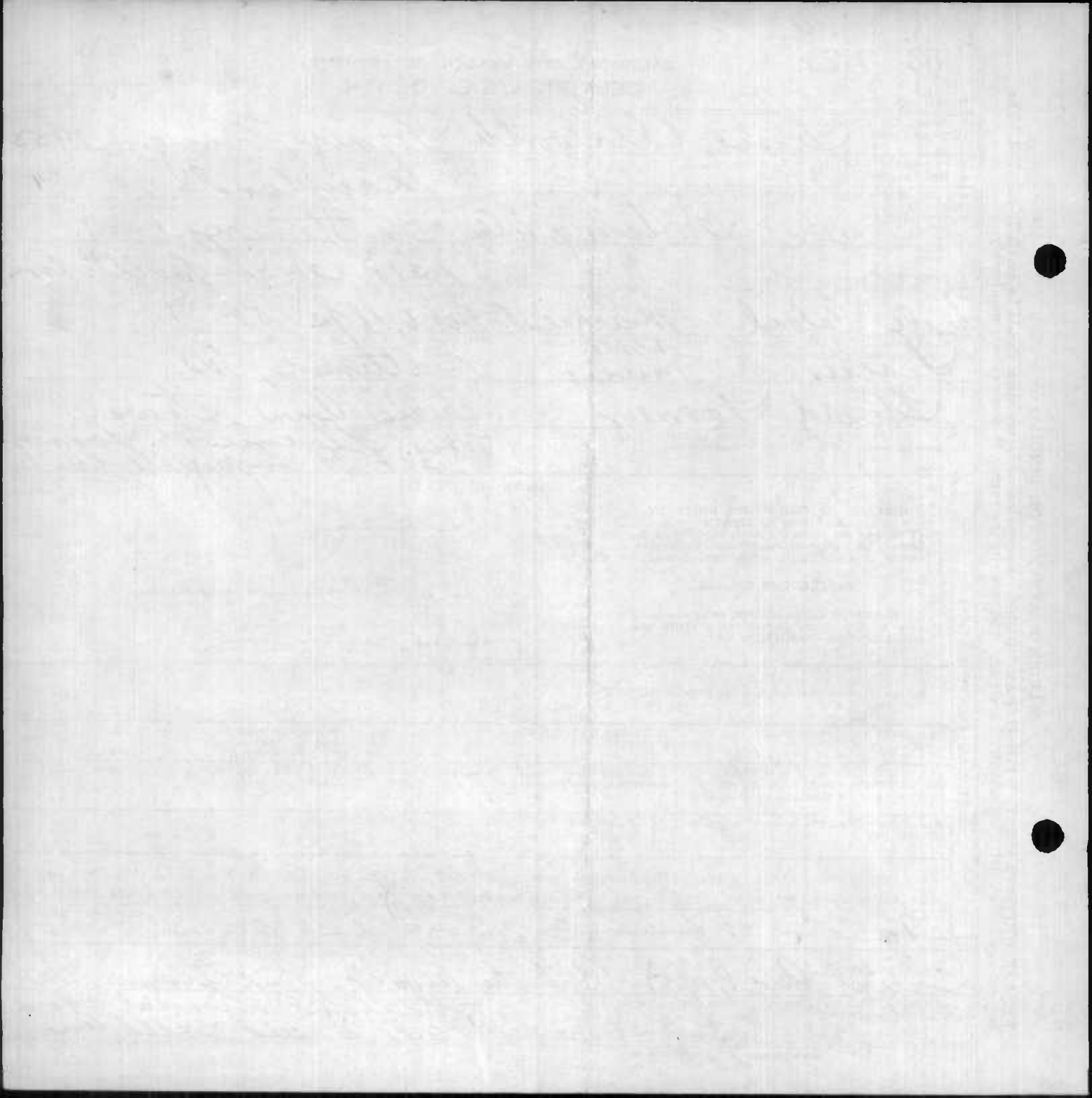
General Home

ADDRESS

6371 Druid Hill Ave.

AUG 7 1953

VS 150



5-350  
53 7124BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

53 7124

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES J. SETTAN

2. DATE  
OF  
DEATH

8/6/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

27-18

D. STREET ADDRESS (If rural, give location)

5302 TIPPETT AVE

B. FULL NAME OF (If not in hospital or institution, give street address or location)

5302 TIPPETT AVE

C. Length of stay in Baltimore

LIFE

Yrs.  
Mos.  
Days

5. SEX

M.

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

AUG. 4 - 1889

9. AGE (In years  
last birthday)

64

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

STAND ENG.

10B. KIND OF BUSINESS OR  
INDUSTRY

ST JOSEPH Hosp.

11. BIRTHPLACE (State or foreign country)

BALTIMORE MD

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HERMAN SETTAN

14. MOTHER'S MAIDEN NAME

HILLEY BISCOE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

219-28-3421

17. INFORMANT

ADDRESS

LULA V. SETTAN 5302 TIPPETT AVE

18. 420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Acute Coronary Thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Anterior-Septal  
Heart Disease

(C)

About  
5 years

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., In or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1948 to 2/6/53, that I last saw the  
deceased alive on March 19, 1953 and that death occurred at 2:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. FUNERAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL

8/10/53

PARKWOOD CEMT.

BALTIMORE

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 7 1953

Huntington Williams, M.D.

C.F. Hoffmann 1639 N. Broadway

5838T





C-625  
53 7185

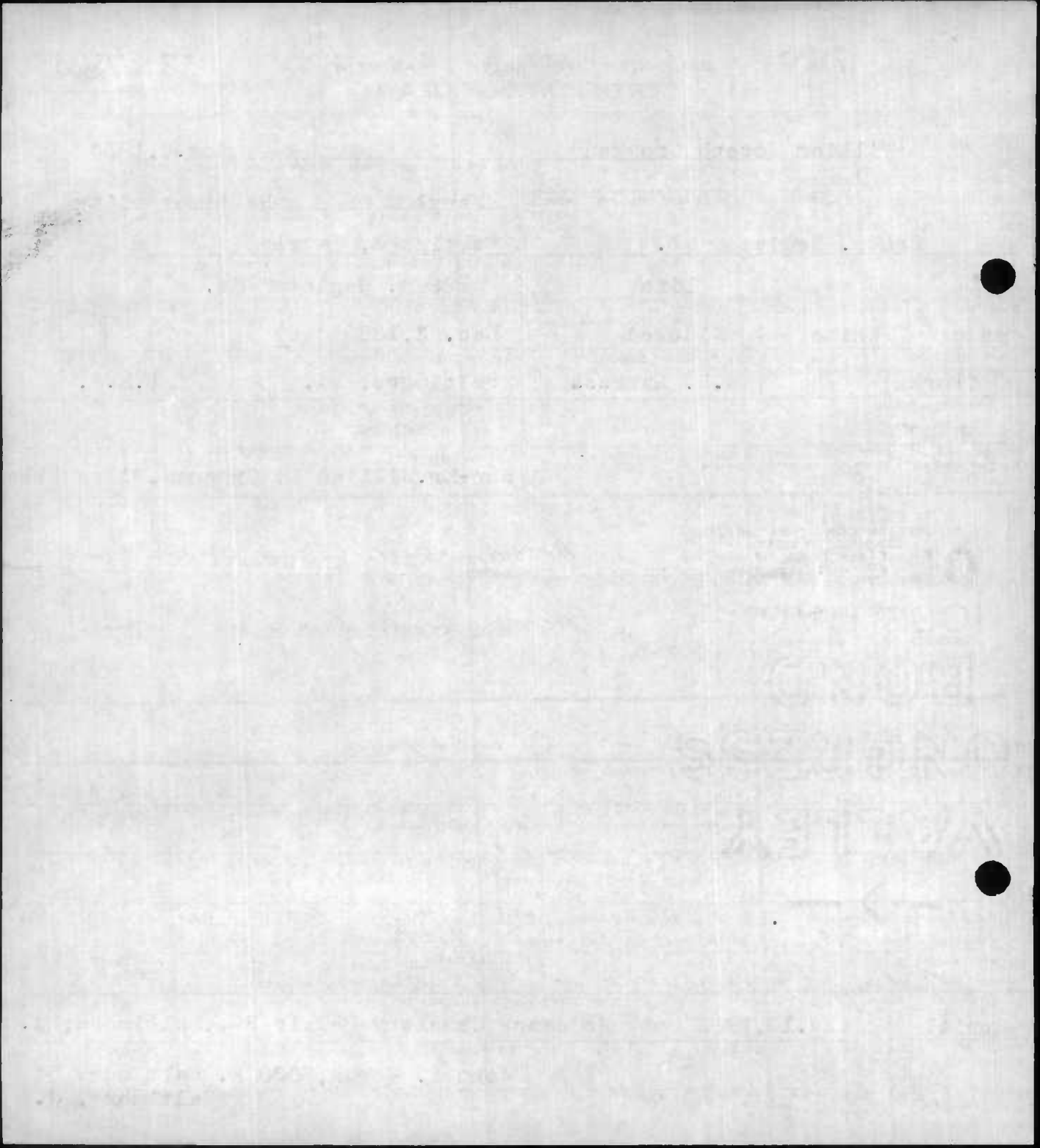
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7185  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>William Joseph Croghan</b>		2. DATE OF DEATH <b>Aug. 6, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore City</b>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>255 S. Register St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore, Maryland 2-02</b>			
C. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>225 S. Register St.</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Dec. 3, 1889</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Year Months Days If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>R.R. Express</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>			
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Son-Mr. William P. Croghan, Pikesville</b>			

18. <b>420.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO <b>ARTERIOSCLEROSIS, GENERALIZED</b> DUE TO <b>CHRONIC NEPHRITIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 YEARS</b> <b>7 YRS.</b> <b>5 YEARS</b>	
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	21D. TIME (Month) (Day) (Year) (Hour) INJURY
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <b>MAY</b> , 1951, to <b>AUG.</b> , 1953, that I last saw the deceased alive on <b>8/5/</b> , 1953, and that death occurred at <b>9:25 A.</b> m., from the causes and on the date stated above.
23A. SIGNATURE <b>Becky B. Moran, M.D.</b>	23B. ADDRESS <b>448 N. Luganul</b>	23C. DATE SIGNED <b>8/7/53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Aug. 10, 1953</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Belair Rd., Baltimore, Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <b>John A. Moran</b>	25. FUNERAL DIRECTOR <b>John A. Moran</b>	ADDRESS <b>3000 E. Baltimore St Baltimore, Md.</b>

067-150  
Huntington Williams, M.D.  
39050



F-640  
53 7186

53 7186

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>John W. Farrell</b>			2. DATE OF DEATH <b>Aug 6, 1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived in institution: residence before admission) A. STATE <b>Ind.</b> B. COUNTY <b>Balt.</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mercy Hosp</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>9-06</b>		
C. Length of stay in Baltimore <b>62</b> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>1925 E. 30th St. (18)</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>2/8/1890</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bldg. Insp.</b>			11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		
10B. KIND OF BUSINESS OR INDUSTRY <b>City</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Edward R. Farrell</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Clarke</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>None</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>World War I</b>			17. INFORMANT <b>Wife.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>World War I</b>			17. INFORMANT <b>Wife.</b>		

18. <b>203X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Multiple Myeloma</b>		CAUSE OF DEATH <b>Multiple Myeloma</b>	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ (C) _____		DUE TO (A) _____ (B) _____ (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7/20</b> 19 <b>53</b> , to <b>7/6</b> 19 <b>53</b> , that I last saw the deceased alive on <b>8/6/</b> 19 <b>53</b> , and that death occurred at <b>7:00 A.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>J. T. Watson</b>		23B. ADDRESS <b>Mercy Hosp.</b>		23C. DATE SIGNED <b>8/6/53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>Aug 10, 1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Fredrick Rd. BALT.</b>		24E. FUNERAL DIRECTOR <b>John H. Moran</b>		24F. ADDRESS <b>3000 E. BALTIMORE, MD.</b>	

AUG 7 1953

210 93

STATE OF NEW YORK  
CERTIFICATE OF DEATH

CAUSE OF DEATH

DECEASED'S SEX AND AGE

DECEASED'S RACE

DECEASED'S BIRTH DATE

DECEASED'S BIRTH PLACE

DECEASED'S MARRIAGE DATE

DECEASED'S MARRIAGE PLACE

DECEASED'S OCCUPATION

DECEASED'S RESIDENCE

DECEASED'S DEATH DATE

DECEASED'S DEATH TIME

DECEASED'S DEATH PLACE

DECEASED'S DEATH CAUSE

DECEASED'S DEATH PLACE

DECEASED'S DEATH PLACE

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DECEASED'S DEATH PLACE

M-425

53 7127

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mulligan, Matthew Bernard

2. DATE  
OF  
DEATH

August 6, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

St. Joseph's Hospital

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

344 E. University Parkway

8. DATE OF BIRTH

Nov 28, 1880

9. AGE (In years  
last birthday)

72

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

CLERK

10B. KIND OF BUSINESS OR  
INDUSTRY

Peoples Court (Walter)

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

MATTHEW B. MULLIGAN

14. MOTHER'S MAIDEN NAME

ANNA BURNS

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

213-20-3831

17. INFORMANT

ADDRESS

JENNIE MULLIGAN 344 E. UNIVERSITY

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.Hypostatic Pneumonia 1 day  
Due to  
Unresected Carcinoma of 1 1/2 years  
Right Cervical Lymph  
Secondary to Cervical Lymph  
Gland metastasis from  
Primary Squamous cell  
Carcinoma of Pharynx 7 years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 10, 1953, to Aug 6, 1953, that I last saw the  
deceased alive on Aug 5, 1953, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 7 1953

VS 150

Huntington William M. Charles A. Evans &amp; Son

39093 118 W. Mt. Royal Ave.

MEDICAL CERTIFICATION

MINNESOTA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of funeral director		12. Signature of medical examiner	
13. Signature of health officer		14. Signature of county auditor		15. Signature of county clerk		16. Signature of county treasurer	
17. Signature of county judge		18. Signature of county sheriff		19. Signature of county assessor		20. Signature of county superintendent	
21. Signature of county clerk		22. Signature of county treasurer		23. Signature of county judge		24. Signature of county sheriff	
25. Signature of county assessor		26. Signature of county superintendent		27. Signature of county clerk		28. Signature of county treasurer	
29. Signature of county judge		30. Signature of county sheriff		31. Signature of county assessor		32. Signature of county superintendent	
33. Signature of county clerk		34. Signature of county treasurer		35. Signature of county judge		36. Signature of county sheriff	
37. Signature of county assessor		38. Signature of county superintendent		39. Signature of county clerk		40. Signature of county treasurer	
41. Signature of county judge		42. Signature of county sheriff		43. Signature of county assessor		44. Signature of county superintendent	
45. Signature of county clerk		46. Signature of county treasurer		47. Signature of county judge		48. Signature of county sheriff	
49. Signature of county assessor		50. Signature of county superintendent		51. Signature of county clerk		52. Signature of county treasurer	
53. Signature of county judge		54. Signature of county sheriff		55. Signature of county assessor		56. Signature of county superintendent	
57. Signature of county clerk		58. Signature of county treasurer		59. Signature of county judge		60. Signature of county sheriff	
61. Signature of county assessor		62. Signature of county superintendent		63. Signature of county clerk		64. Signature of county treasurer	
65. Signature of county judge		66. Signature of county sheriff		67. Signature of county assessor		68. Signature of county superintendent	
69. Signature of county clerk		70. Signature of county treasurer		71. Signature of county judge		72. Signature of county sheriff	
73. Signature of county assessor		74. Signature of county superintendent		75. Signature of county clerk		76. Signature of county treasurer	
77. Signature of county judge		78. Signature of county sheriff		79. Signature of county assessor		80. Signature of county superintendent	
81. Signature of county clerk		82. Signature of county treasurer		83. Signature of county judge		84. Signature of county sheriff	
85. Signature of county assessor		86. Signature of county superintendent		87. Signature of county clerk		88. Signature of county treasurer	
89. Signature of county judge		90. Signature of county sheriff		91. Signature of county assessor		92. Signature of county superintendent	
93. Signature of county clerk		94. Signature of county treasurer		95. Signature of county judge		96. Signature of county sheriff	
97. Signature of county assessor		98. Signature of county superintendent		99. Signature of county clerk		100. Signature of county treasurer	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

R-560  
53 7128

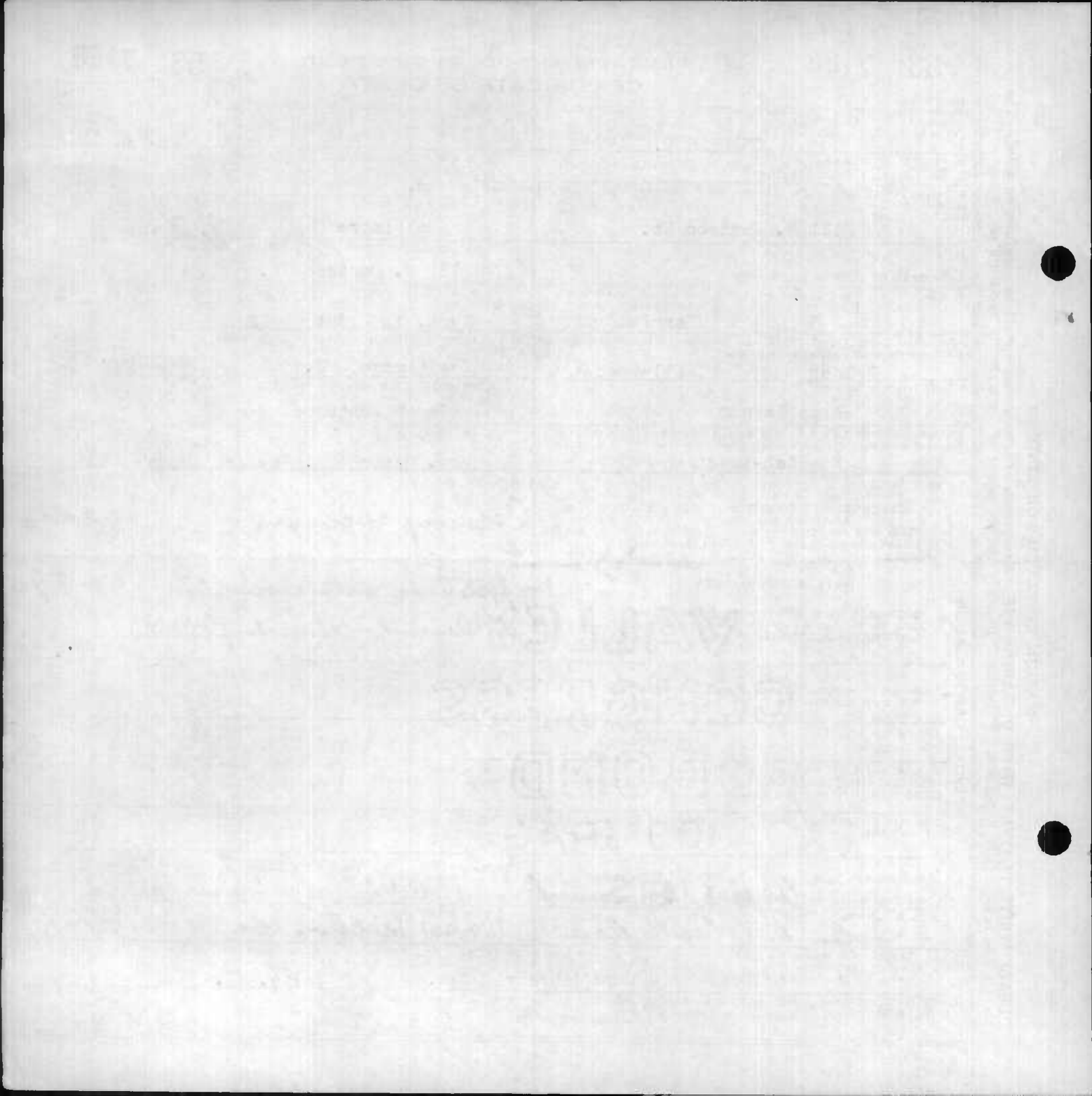
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7128

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		CHARLES B. RAYNOR		Aug. 5, 1953	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		Md.	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		Baltimore	
121 N. Denison St.		D. STREET ADDRESS (If rural, give location)		121 N. Denison St.	
c. Length of stay in Baltimore		Yrs. Mos. Days			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months; Days
M	W	Married	Sept. 13, 1880	72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
Welder		Rail-Road	Baltimore, Md.	USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
George Raynor		Sarah Montague			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
Yes		Spanish-American	Mrs. Blanche E. Raynor Above		
18. 4201 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
		(A) <i>Cormany occlusion</i>		2 days	
ANTECEDENT CAUSES		(B) <i>Hypertensive arteriosclerotic</i>		7-8 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) <i>C.V. Disease - Coronary Arteriosclerosis</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 1946 to Aug 5, 1953, that I last saw the deceased alive on Aug 5, 1953 and that death occurred at 11:30 p.m., from the causes and on the date stated above.		23A. SIGNATURE		23B. ADDRESS	
		John F. Coalahan M. D.		4201 Walkers St	
23C. DATE SIGNED		24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE	
8/7/53		Burial		8/10/53	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county)		(State)	
New Cathedral Cem.		Balto. Md.			
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR ADDRESS	
Huntington, Williams, M.D.				John J. Tucker, Sons Inc. Balto Md	

VS 150 1953

68550



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-453 53 7129		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		53 7129 Registered No.	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>Alice M. Blount</b>				2. DATE OF DEATH <b>August 6, 1953</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <b>2231 Crest Road</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 27-15</b>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>2231 Crest Road</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>February 19, 1879</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (State or foreign country) <b>Chicago, Illinois</b>
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <b>Charles E. Hill</b>		
14. MOTHER'S MAIDEN NAME <b>Mary E. Ludlow</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <b>Harry Blount, 2231 Crest Road</b>		
18. 170X CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO <b>Metastatic Carcinoma of Lung</b> 19VD. ANTECEDENT CAUSES DUE TO <b>C. of Breast</b> 19VD. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)			
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 7, 1953</u> , to <u>Aug. 6, 1953</u> , that I last saw the deceased alive on <u>Aug. 6, 1953</u> , and that death occurred at <u>4 P. m.</u> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Joseph L. Blount</i>		23B. ADDRESS <i>11 N. h. Calver St.</i>		23C. DATE SIGNED <i>8/6/53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		24B. DATE <b>8/8/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oakridge Cemetery</b>	
24D. LOCATION (City, town, county) (State) <b>Chicago, Illinois</b>		25. FUNERAL DIRECTOR ADDRESS <b>Huntington Williams, Mort. M. Cook, Inc., 1217 St. Paul Street</b>			

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⑥  
L-2730 7130  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7130  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>William Loechel</b>		2. DATE OF DEATH <b>Aug. 6/53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1523 Carswell St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>9-07</b>	
D. LENGTH OF STAY IN BALTIMORE <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>1523 Carswell St.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 13, 1890</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telegraph Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. R. R.</b>	
13. FATHER'S NAME <b>John Loechel</b>		14. MOTHER'S MAIDEN NAME <b>Marie Krodel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Minnie Loechel</b>		ADDRESS <b>1523 Carswell St</b>	

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Apoplexy.</b>		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO <b>Arteriosclerosis Cordis</b>		
(B) DUE TO <b>Arteriosclerosis</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>Jan 1, 1952</b> to <b>Aug 6, 1953</b> that I last saw the deceased alive on <b>Aug 6, 1953</b> and that death occurred at <b>8:30 a. m.</b> , from the causes and on the date stated above.				
23A. SIGNATURE <b>[Signature]</b>		23B. ADDRESS <b>3033 Woodmont</b>		23C. DATE SIGNED <b>8/6/53</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Aug. 8/53</b>	24C. NAME OF CEMETERY OR CREMATORY <b>London Park</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore 29, Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>Aug 7 1953</b>		25. FUNERAL DIRECTOR <b>[Signature]</b> ADDRESS <b>4101 Edmondson Ave.</b>	

36550

MEDICAL CERTIFICATION

100-100000

RECEIVED

100000

100000



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. **53 7131**

 BIRTH NO. **10745**

 1. NAME OF DECEASED  
(Type or Print)

**Stapley Peade**

 2. DATE OF DEATH **Aug. 7, 1953**

3. PLACE OF DEATH

A. Baltimore City, Maryland

**Peade 1210 3W**

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

 A. STATE **DC**

 B. COUNTY **V-48**

B. FULL NAME OF HOSPITAL OR INSTITUTION

**JOHNS HOPKINS HOSPITAL**

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

**Washington**

D. STREET ADDRESS (If rural, give location)

**138 Tennessee Ave**

c. Length of stay in Baltimore

 Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOW, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

 If Under 1 Year Months Days  
If Under 24 Hours Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**Gary Peade**

14. MOTHER'S MAIDEN NAME

**Brucilla**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

**JOHNS HOPKINS HOSPITAL**

 18. **193X**

CAUSE OF DEATH

 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

 22. I hereby certify that I attended the deceased from **7-3-53**, to **8-7-53**, that I last saw the deceased alive on **8-7-53** and that death occurred at **8:35 a.m.**, from the causes and on the date stated above.

23A. SIGNATURE

**Victor Gunne**

M. D.

23B. ADDRESS

**JOHNS HOPKINS HOSPITAL**

23C. DATE SIGNED

**8/7/53**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

 AUG 8 1953  
VS 150

**Huntington Williams, M.D., Funeral Home 389 P. Ave. Washington, D.C.**

THE UNIVERSITY OF CHICAGO  
LIBRARY

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F. S. V.

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GOVERNMENT

VALLEY

Handwritten signature

Handwritten signature

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W. 550  
53 7132BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7132

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary Wiechman

2. DATE  
OF  
DEATH

Aug 7, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Med. 0-13

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

B. COUNTY

before admission)

Md.

27-38

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1403 Lochner Road

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 451X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Rupture of Abdominal  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Arteriosclerosis  
DUE TO  
(C)INTERVAL BETWEEN  
ONSET AND DEATH

18 hrs

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-7-1953 to 8-7-1953, that I last saw the  
deceased alive on 8-7-1953 and that death occurred at 3:06 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Lawrence L. Ured M.D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

8/7/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

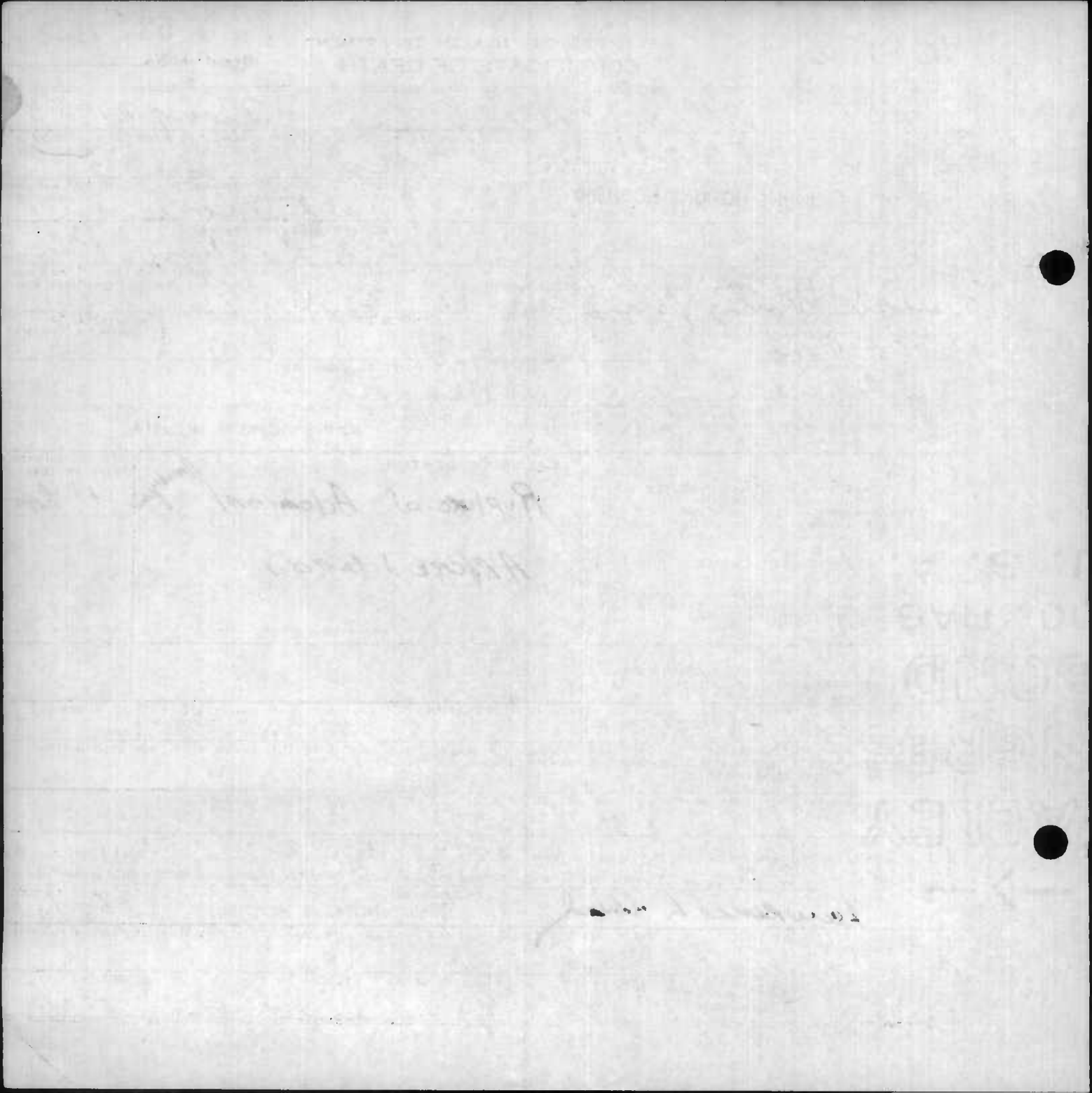
ADDRESS

AUG 8 1953

Huntington Williams, M.D.

J. J. Buck

5305 Harford Rd



H-200  
53 7133

HICKEY  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7133  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Louise Hickey</i>		2. DATE OF DEATH <i>Aug 7-1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>Balt</i>			
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>6712 Harford Rd.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balt</i> <i>27-07</i>			
6. LENGTH OF stay in Baltimore <i>40-</i>		D. STREET ADDRESS (If rural, give location) <i>6712 Harford Rd</i>			
5. SEX <i>fm</i>	6. COLOR OR RACE <i>w</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>4-12-1893</i>	9. AGE (In years last birthday) <i>60</i>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Portsmouth Va</i>	
13. FATHER'S NAME <i>Walter J. Lee</i>		14. MOTHER'S MAIDEN NAME <i>Julia Henry</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Joseph B. Hickey</i> ADDRESS <i>6712 Harford</i>	
18. <i>180X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Nephrosclerosis of Lt. side.</i> DUE TO (B) <i>Generalized Carcinoma</i> DUE TO <i>metastatic</i> (C) <i>(Patient of Dr. Edward Aless.) who is on vacation.</i>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>7 Aug</i> , 19 <i>53</i> , to <i>7 Aug</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>7 Aug</i> , 19 <i>53</i> , and that death occurred at <i>8:30</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>James E. White</i>		M. D.		23B. ADDRESS <i>5214 Harford Rd</i>	23C. DATE SIGNED <i>8 Aug 53</i>
24A. (BURIAL, CREMATION, REMOVAL) (Specify) <i>Buried</i>		24B. DATE <i>8/10/53</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Cathedral</i>		24D. LOCATION (City, town, or county) (State) <i>Balt</i> <i>md</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 8 1953</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>		25. FUNERAL DIRECTOR <i>W. Ruck</i> ADDRESS <i>5305 Harford Rd</i>	

MEDICAL CERTIFICATION

Mr James White



53 7134

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7134

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Anthony Jeffri*

2. DATE  
OF  
DEATH

*Aug 7-1953*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

*2939 Erdman Ave.*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY

*2939 Erdman Ave 8-61*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Balt Md*

D. STREET ADDRESS (If rural, give location)

*2939 Erdman Ave*

5. SEX

*M*

6. COLOR OR RACE

*W*

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

*Married*

8. DATE OF BIRTH

*2-25-1892*

9. AGE (in years  
last birthday)

*61*

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

*Confectionery*

10B. KIND OF BUSINESS OR  
INDUSTRY

*Same*

11. BIRTHPLACE (State or foreign country)

*Balt Md*

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

*John Jeffri*

14. MOTHER'S MAIDEN NAME

*Concetta*

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

*No*

16. SOCIAL  
SECURITY NO.

*10*

17. INFORMANT

*Julius Jeffri*

ADDRESS

*2939 Erdman Ave*

18. *151X*

CAUSE OF DEATH

*Carcinoma of Stomach*

INTERVAL BETWEEN  
ONSET AND DEATH

*?*

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Jan 10*, 19*53*, to *August 7*, 19*53*, that I last saw the  
deceased alive on *July 24*, 19*53*, and that death occurred at *6 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Looseeul Kipm*

23B. ADDRESS

*1261 E Mt St*

23C. DATE SIGNED

*8-8-53*

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

*Burn*

24B. DATE

*8/10/53*

24C. NAME OF CEMETERY OR CREMATORY

*Holy Redeemer*

24D. LOCATION (City, town, or county)

*Balt Md*

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

*AUG 8 1953*

REGISTRAR'S SIGNATURE

*Huntington Hollis*

25. FUNERAL DIRECTOR

*55305 Warford Rd*

ADDRESS

*55305 Warford Rd*

Mr. Legum  
1761 E. North Ave

S-415

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7135  
Registered No.53 7135  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Emma D. Sullivan</i>			2. DATE OF DEATH <i>Aug. 7/1953</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>Maryland General Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>13-08</i>		
D. STREET ADDRESS (If rural, give location) <i>3675 Ash St. #11</i>					
5. SEX <i>F</i>			6. COLOR OR RACE <i>W</i>		
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>			8. DATE OF BIRTH <i>Dec. 20, 1874</i>		
9. AGE (in years last birthday) <i>78 yrs.</i>			10. Under 1 Year Months: Days: Hours: Min.		
11. BIRTHPLACE (State or foreign country) <i>Kentucky</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Allen Vance</i>			14. MOTHER'S MAIDEN NAME <i>Sarah Pendleton</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Arlene Sullivan</i>			ADDRESS <i>3675 Ash St. #11</i>		

18. <i>443X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Hypertensive Cardio-vascular</i> DUE TO <i>disease with heart failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 mos.</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Aug. 4</i> , 1953, to <i>Aug. 7</i> , 1953, that I last saw the deceased alive on <i>Aug. 7</i> , 1953, and that death occurred at <i>1:17 P m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Valeriana B. Castillo</i>		23B. ADDRESS <i>Ind. General Hospital</i>		23C. DATE SIGNED <i>8/7/53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>Aug 13 - 53</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Sullivan</i>	
24D. LOCATION (City, town, or county) <i>More Run</i>		24E. STATE <i>Va.</i>			
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 8 1953</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>		25. FUNERAL DIRECTOR <i>E. Donovan</i>	
				ADDRESS <i>3818 Roland Ave</i>	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7187

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7187

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Emma Lang

2. DATE  
OF  
DEATH

August 6, 1953.

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2408 W. Lanvale St.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2408 W. Lanvale St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Jan. 10, 1870

9. AGE (In years  
last birthday)

83

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Ilg

14. MOTHER'S MAIDEN NAME

Amelia Schmidt

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS

Mrs. Lester Hoffman 2408 W. Lanvale St.

18. 332X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Cerebral Thrombosis

1 wk

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Cerebral Arteriosclerosis years

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II20. AUTOPSY?  
YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1, 1953 to August 6, 1953, that I last saw the  
deceased alive on Aug 6, 1953, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE

S. Mendel

M. O.

23B. ADDRESS

651 N. Bentalon

23C. DATE SIGNED

8/6/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8/10/53

24C. NAME OF CEMETERY OR CREMATORY

Holy Cross

24D. LOCATION (City, town, or county)

Brooklyn A A Co. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

AUG 8 1953

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Wm J. Dickertson

ADDRESS

Wm J. Dickertson

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T 640  
53 7138

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7138

BIRTH NO.

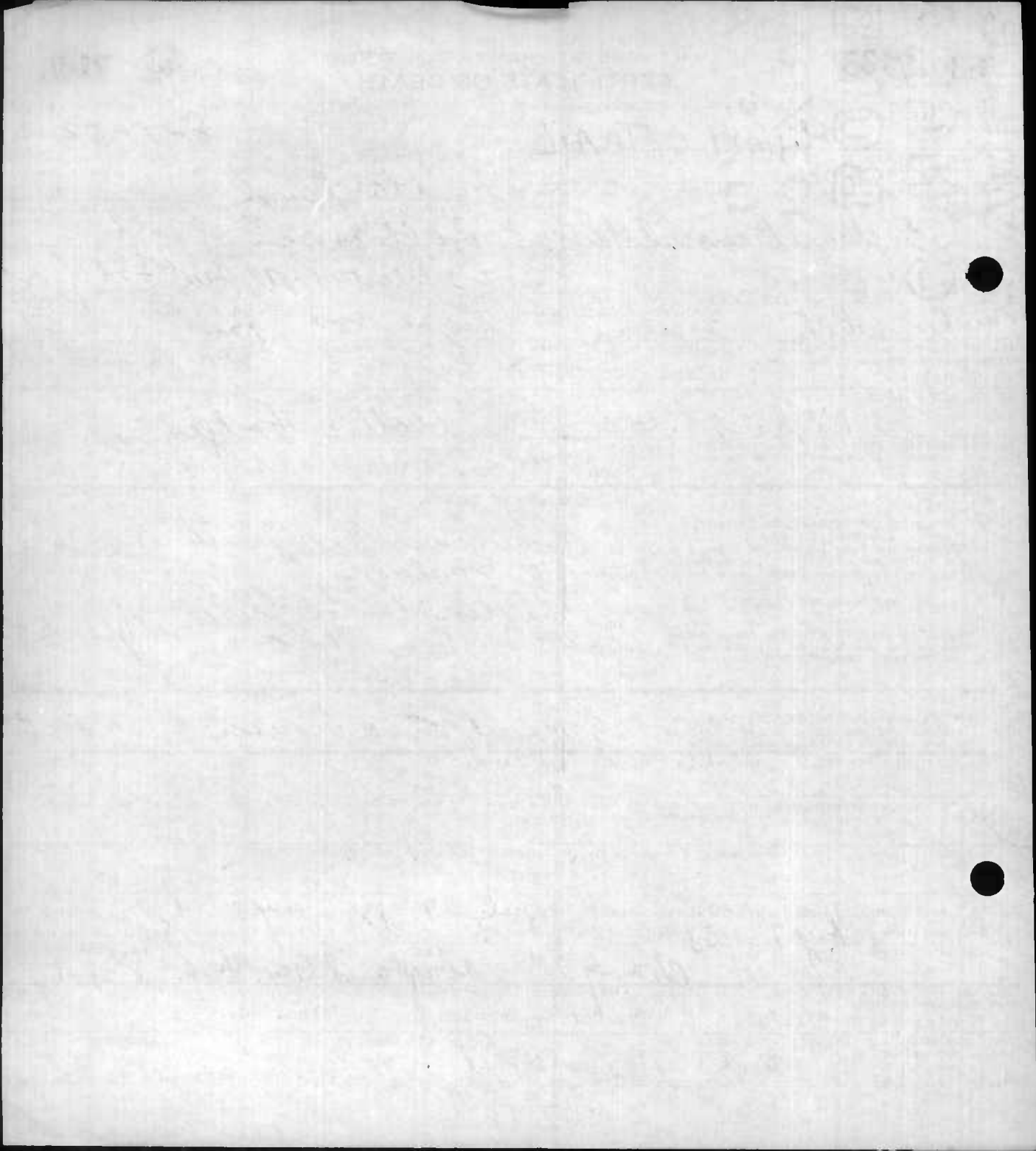
1. NAME OF DECEASED (Type or Print) <b>Millard C TRAIL</b>			2. DATE OF DEATH <b>8-7-53</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Maryland General Hosp</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <b>Baltimore 12-05</b>		
C. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>23 West North Ave #1 1/2 rd floor</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Aug 22, 1880</b>		9. AGE (in years last birthday) <b>72</b> H Under 1 Year Months: Days: I Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Caretaker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. Country Club</b>		11. BIRTHPLACE (State or foreign country) <b>Rockville, Md.</b>	
13. FATHER'S NAME <b>Richard F. Trail</b>			14. MOTHER'S MAIDEN NAME <b>Mollie Hodges</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>Mrs. Edith Trail, 23. W. North Ave.</b>	

MEDICAL CERTIFICATION

18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Decompensation &amp; Failure</b>			CAUSE OF DEATH <b>Cardiac Decompensation &amp; Failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2-3 wks</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arteriosclerotic Cardiovascular Disease</b>			(B) <b>Arteriosclerotic Cardiovascular Disease</b>			years -		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT. <b>Bronchopneumonia</b>			<b>Bronchopneumonia</b>			2 wks -		
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <b>July 24, 1953</b> to <b>Aug 7, 1953</b> that I last saw the deceased alive on <b>Aug 7, 1953</b> , and that death occurred at <b>m.</b> , from the causes and on the date stated above.								
23A. SIGNATURE <b>Chang M. D.</b>			23B. ADDRESS <b>Maryland Gen. Hosp.</b>			23C. DATE SIGNED <b>8-7-53</b>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/11/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Hampden</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 8 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>Wm. J. Tichner, Sons Inc. Balto Md</b>		ADDRESS		

VS 150

9708M



V-230  
53 7139BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7139  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

EMMA D. VOGT

2. DATE  
OF  
DEATH

Aug. 7, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Md

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR  
INSTITUTION

1027 Haverhill Rd.

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1027 Haverhill Rd.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Single

8. DATE OF BIRTH

Dec. 3, 1870

9. AGE (in years  
last birthday)

82

If Under 1 Year

Months

Days

If Under 24 Hours

Hours

Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Home

10B. KIND OF BUSINESS OR  
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Balto. Co. Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Jacob Vogt

14. MOTHER'S MAIDEN NAME

Hannah Goldner

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS

Mrs. Ella V. Weaver 108 Dunkirk Rd. 12

18.

450.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic gangrene, left leg

3 months

DUE TO Chronic congestive cardiac failure

2 years

## ANTECEDENT CAUSES

(B) Arteriosclerosis, advanced, generalized years

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

none

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II20. AUTOPSY? ☒ YES ☐ NO ☒ XX21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 16, 1953, to August 7, 1953, that I last saw the  
deceased alive on August 7, 1953, and that death occurred at 8:20P m., from the causes and on the date stated above.

23A. SIGNATURE

Donald E. Fisher M.D.

23B. ADDRESS

1707 Edmondson Ave. Catonsville

23C. DATE SIGNED

August 8, 1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8/10/53

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State) 3

DATE RECEIVED BY  
LOCAL REGISTRAR

AUG 8 1953

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wm. J. Tucker Sons, Inc. Balt Md

ADDRESS

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**BALTIMORE CITY HEALTH DEPARTMENT**  
**CERTIFICATE OF DEATH**

Registered **53 7140**

BIRTH NO. **53 7140**

1. NAME OF DECEASED (Type or Print) **WALTER DRUMMOND**

2. DATE OF DEATH **August 5, 1953**

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE **Maryland** B. COUNTY

5. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore 19-02**

6. STREET ADDRESS (If rural, give location)  
**1512 W. Lexington Street**

7. Length of stay in Baltimore **22** Yrs. Mos. Days

8. SEX **Male** 9. COLOR OR RACE **Colored** 10. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **Married**

11. DATE OF BIRTH **Oct 20 - 1918** 12. AGE (In years last birthday) **35** 13. If Under 1 Year Months: Days 14. If Under 24 Hours Hours: Min.

15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Laborer** 16. KIND OF BUSINESS OR INDUSTRY

17. BIRTHPLACE (State or foreign country) **Sparksburg Va** 18. CITIZEN OF WHAT COUNTRY?

19. FATHER'S NAME **James Drummond** 20. MOTHER'S MAIDEN NAME **Lissie Gleason**

21. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) **yes** 22. SOCIAL SECURITY NO. **216-10-8057** 23. INFORMANT **Elias Drummond** ADDRESS **602 N. Appleton**

24. **E981X** CAUSE OF DEATH

(A) **Gunshot wound of chest**

(B) **Massive bilateral thoracic hemorrhage**

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

25. DATE OF OPERATION 26. MAJOR FINDINGS OF OPERATION 27. AUTOPSY? YES ☒ NO ☐

28. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 29. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) **Home** 30. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **1512 W. Lexington Street**

31. TIME (Month) (Day) (Year) (Hour) OF INJURY **Aug. 5, 1953 11:00 P. m.** 32. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 33. HOW DID INJURY OCCUR? **Shot in chest by wife during altercation**

34. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

35. SIGNATURE **William H. [Signature]** 36. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ 37. DATE SIGNED **August 6, 1953**

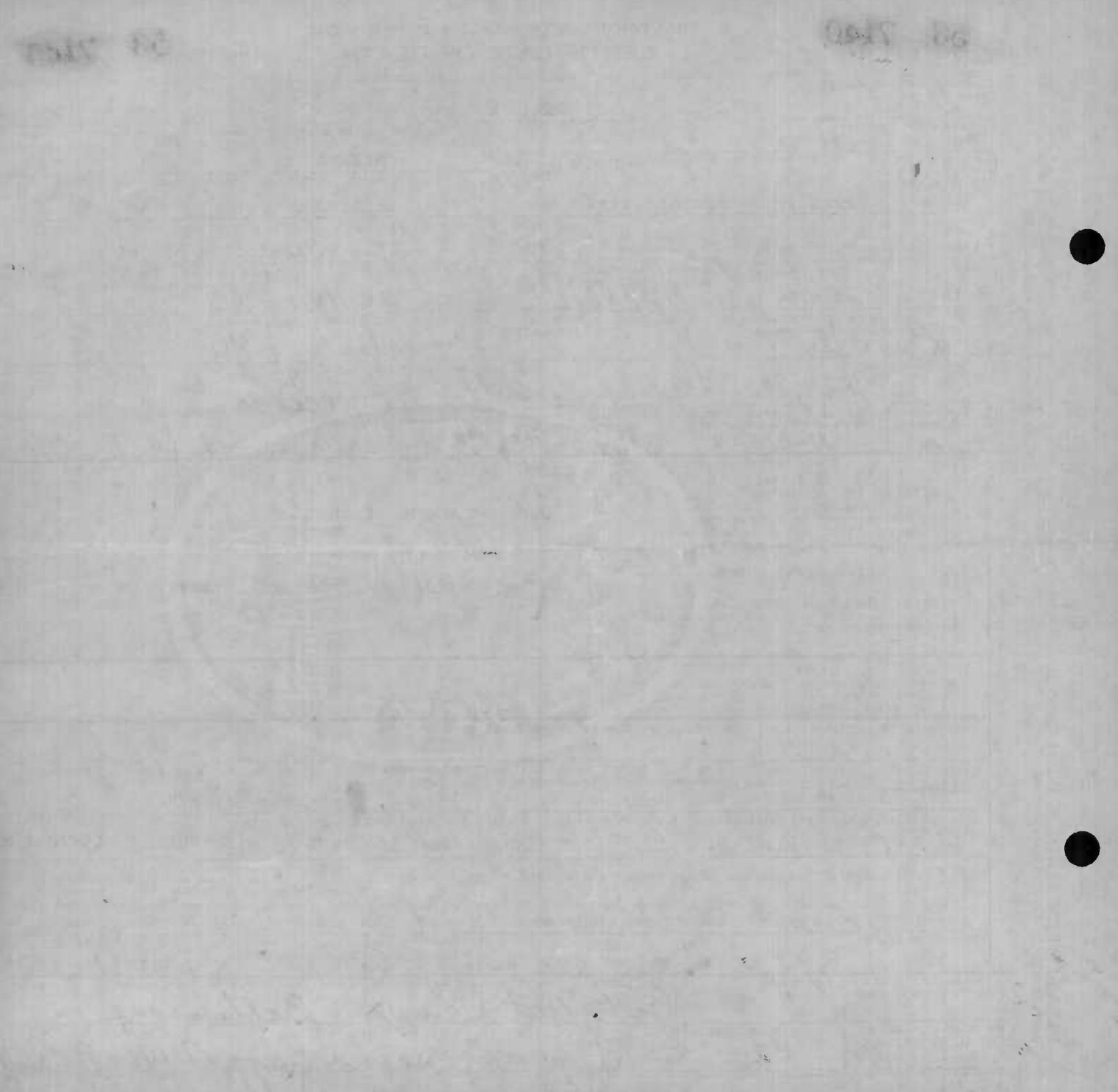
38. BURIAL, CREMATION, REMOVAL (Specify) 39. DATE 40. NAME OF CEMETERY OR CREMATORY **Balto Nat Cemetery** 41. LOCATION (City, town, or county) (State) **Baltimore**

42. DATE RECEIVED BY LOCAL REGISTRAR **AUG 8 1953** 43. REGISTRAR'S SIGNATURE **Huntington Williams** 44. FUNERAL DIRECTOR **Brooks Guggold** ADDRESS **1463 N. Carey**

VS 151 **N 862.4** **97099**

TSNY PC

0017 86



W-453  
53 7141BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7141  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Wieland, August</b>		2. DATE OF DEATH <b>August 8, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>St. Joseph's Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>			
D. STREET ADDRESS (If rural, give location) <b>4221 Kolb Avenue</b>		E. LENGTH OF STAY IN BALTIMORE <b>Life</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b>	8. DATE OF BIRTH <b>67 yrs.</b>	9. AGE (In years last birthday) <b>67 yrs.</b>	10. UNDER 1 Year Months Days 11. UNDER 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>William J. Wieland</b>		14. MOTHER'S MAIDEN NAME <b>Mary ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Geo. G. G. Wieland 519 Orkney Road</b>	
18. <b>581.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Hepatic Coma</b> DUE TO <b>Antecedent Causes</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Cirrhosis of the Liver</b> DUE TO <b>Other Significant Conditions Contributing to the Death, but not related to the disease or condition causing it.</b>		CAUSE OF DEATH <b>Hepatic Coma</b> <b>Cirrhosis of the Liver</b>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 23, 1953</b> to <b>August 8, 1953</b> , that I last saw the deceased alive on <b>August 8, 1953</b> and that death occurred at <b>6:50 a.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>R. Cassinelli</b>		23B. ADDRESS <b>1400 N. Caroline Street</b>		23C. DATE SIGNED <b>August 8, 1953</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-8-53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Schwartz's</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		24E. DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 9 1953</b>		24F. REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	
24G. FUNERAL DIRECTOR <b>Wiley &amp; Zeiler, Inc.</b>		24H. ADDRESS <b>403 S. Wolfe Street</b>		24I. VS 150	

100-100000

RECEIVED THE CITY OF BIRMINGHAM  
CERTIFICATE OF DEATH

100-100000

THIS IS TO CERTIFY THAT the within and foregoing is a true and correct copy of the original as the same appears from the records of the City of Birmingham, Alabama, in the office of the Registrar of the City of Birmingham, Alabama, on this 10th day of 1900.

W. J. BROWN, Registrar of the City of Birmingham, Alabama.

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the City of Birmingham, Alabama, at Birmingham, Alabama, this 10th day of 1900.

W. J. BROWN, Registrar of the City of Birmingham, Alabama.

100-100000

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

53 7142  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Hevener, Lester Dorsey

2. DATE  
OF  
DEATH

August 8, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Bato

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MD.

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

St. Joseph's Hospital

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore, Maryland

8-05

C. Length of stay in Baltimore

45 yrs.

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

1827 N. Castle St.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

2-4-96

9. AGE (In years last birthday)

57

11 Under 1 Year  
Months: Days

11 Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Social Security

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT  
Catherine Hevener

ADDRESS  
same

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-Vascular Accident

DUE TO Cerebral hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis, generalized

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from August 6, 1953, to August 8, 1953 that I last saw the deceased alive on August 8, 1953 and that death occurred at 1:37a m., from the causes and on the date stated above.

23A. SIGNATURE

Nathaniel O. Santiago

M. D.

23B. ADDRESS

1400 N. Caroline Street

23C. DATE SIGNED

August 8, 1953

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-8-53

24C. NAME OF CEMETERY OR CREMATORY

Balto. National

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Gilly & Zeiler, Inc. 403 S. Wolfe Street

1915

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LEONARD W. PATON

2. DATE  
OF  
DEATH

August 6, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (not in hospital or institution, give street address or location)

Maryland General Hospital

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

13-02

D. STREET ADDRESS (If rural, give location)

2003 Bolton Street

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Aug 2 - 1904

9. AGE (In years  
last birthday)

49

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Bus Driver

10B. KIND OF BUSINESS OR  
INDUSTRY

Baltimore Annapolis

13. FATHER'S NAME

Elmer Patton

14. MOTHER'S MAIDEN NAME

Mrs Marchant

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Gladys Erb - 3149 Parkside Rd, Col. 13

18. E976x

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Gunshot wound of head

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

2003 Bolton Street

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

Aug. 6, 1953 8:00 P.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self in head

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE

William Wood

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

August 7, 1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

Aug 8 - 1953

24C. NAME OF CEMETERY OR CREMATORY

White Oak Cemetery Fayette Co - Ohio

24D. LOCATION (City, town, or county)

Fayette Co - Ohio

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Tom Cook, Inc. - 1217 St Paul St

ADDRESS

AUG 9 1953

N 803,4

62551

SAIT 63

SAIT 63

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. **53 7144**

BIRTH NO. **53 7144**

1. NAME OF DECEASED (Type or Print) <b>Margaret Mc Blaskey</b>		2. DATE OF DEATH <b>August 8-1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>2930 E. Biddle St</b>		4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) A. STATE <b>MD.</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <b>Baltimore 26-34</b>	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <b>1051 Perew Way - Armitstead Gardens</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Dec-31-1875</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	9. AGE (In years, last birthday) <b>78</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Thomas H. Donnelly</b>		14. MOTHER'S MAIDEN NAME <b>Rose Durny</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>5</b>	
17. INFORMANT <b>Wm. H. McCluskey</b>		ADDRESS <b>1051 Perew Way</b>	

18. <b>422.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arteriosclerotic C.V.D.</b>		<b>10 yrs.</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>8/7/53</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>2/3</b> , 1953, to <b>8/8</b> , 1953, that I last saw the deceased alive on <b>8/7/53</b> , 1953 and that death occurred at <b>8:30</b> m., from the causes and on the date stated above.							
23A. SIGNATURE <b>J. Karl Shorman</b>				23B. ADDRESS <b>1212 N. Patterson Rd. Armitstead Gardens</b>		23C. DATE SIGNED <b>8/8/53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <b>8-11-53</b>		24C. NAME OF CEMETERY, OR CREMATORY <b>Balto. Mt. Carmel Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>		25. FUNERAL DIRECTOR <b>John P. Kelly</b>		ADDRESS <b>2435 E. Oliver St</b>	

AUG 9 1953  
VS 150

MMT 28

MMT 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-516 53 7145 BIRTH NO. <i>1011</i>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		53 7145 Registered No.	
1. NAME OF DECEASED (Type or Print) <i>Carol Weinberger</i>			2. DATE OF DEATH <i>Aug 8 '53</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Room 124-2</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Ohio</i> B. COUNTY <i>V-32</i>		
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Cleveland</i>		
6. Length of stay in Baltimore Yrs. <i>35</i> Mos. Days			D. STREET ADDRESS (If rural, give location) <i>2506 Laurelhurst Drive</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Child</i>	8. DATE OF BIRTH <i>3-25-53</i>	9. AGE (In years last birthday) <i>4</i>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <i>Cleveland Ohio</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Eric Weinberger</i>			14. MOTHER'S MAIDEN NAME <i>Eva Grant</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		
18. <i>754.4</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Crynine Heart Disease</i> DUE TO INTERVAL BETWEEN ONSET AND DEATH <i>Smile Butn</i>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) DUE TO (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		19C. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Aug. 6, 1953</i> to <i>Aug 8, 1953</i> , that I last saw the deceased alive on <i>Aug 8, 1953</i> , and that death occurred at <i>10:05 a.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Amsterdam</i>		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>8/8/53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>8-8-53</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Cleveland Ohio</i>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>		25. FUNERAL DIRECTOR ADDRESS <i>Jack Lewis, Inc 2100 Canton Pl</i>	

AUG 9 1953

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Guthrie



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAF-153768 7146 M-233		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		53 7146 Registered No.	
1. NAME OF DECEASED (Type or Print) <b>Carla M. Mastin</b>			2. DATE OF DEATH <b>Aug. 7, 1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION <b>Baltimore City Hospital</b> <b>4940 Eastern Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>25-04</b>		
c. Length of stay in Baltimore <b>13 yrs.</b> Yrs. Mos. Days			O. STREET ADDRESS (If rural, give location) <b>B. C. H. 4940 Eastern Ave.</b> <b>3914 10th St</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 6, 1911</b>	9. AGE (in years last birthday) <b>42</b>	If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>
13. FATHER'S NAME <b>Henry Burke (dec.)</b>			14. MOTHER'S MAIDEN NAME <b>Susie Kyker</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>B. C. H. 4940 Eastern Ave. (records)</b> ✓		
18. <b>002X</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Tuberculosis</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>10-1-52</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Total Hysterectomy</b>		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>11-8</b> , 19 <b>51</b> , to <b>8-7</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>8-7</b> , 19 <b>53</b> , and that death occurred at <b>2:10 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>H. John Doe</b>		23B. ADDRESS <b>4940 Eastern Ave., Balto., Md.</b>		23C. DATE SIGNED <b>8-7-1953</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>Aug. 16, 1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens</b>	
24D. LOCATION (City, town, or county) (State) <b>ARLINGTON, VA</b>		25. FUNERAL DIRECTOR <b>George J. Gorce</b>		ADDRESS <b>461 Ritchie Hwy</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>9 1953</b>		REGISTRAR'S SIGNATURE <b>H. J. Gorce</b>			

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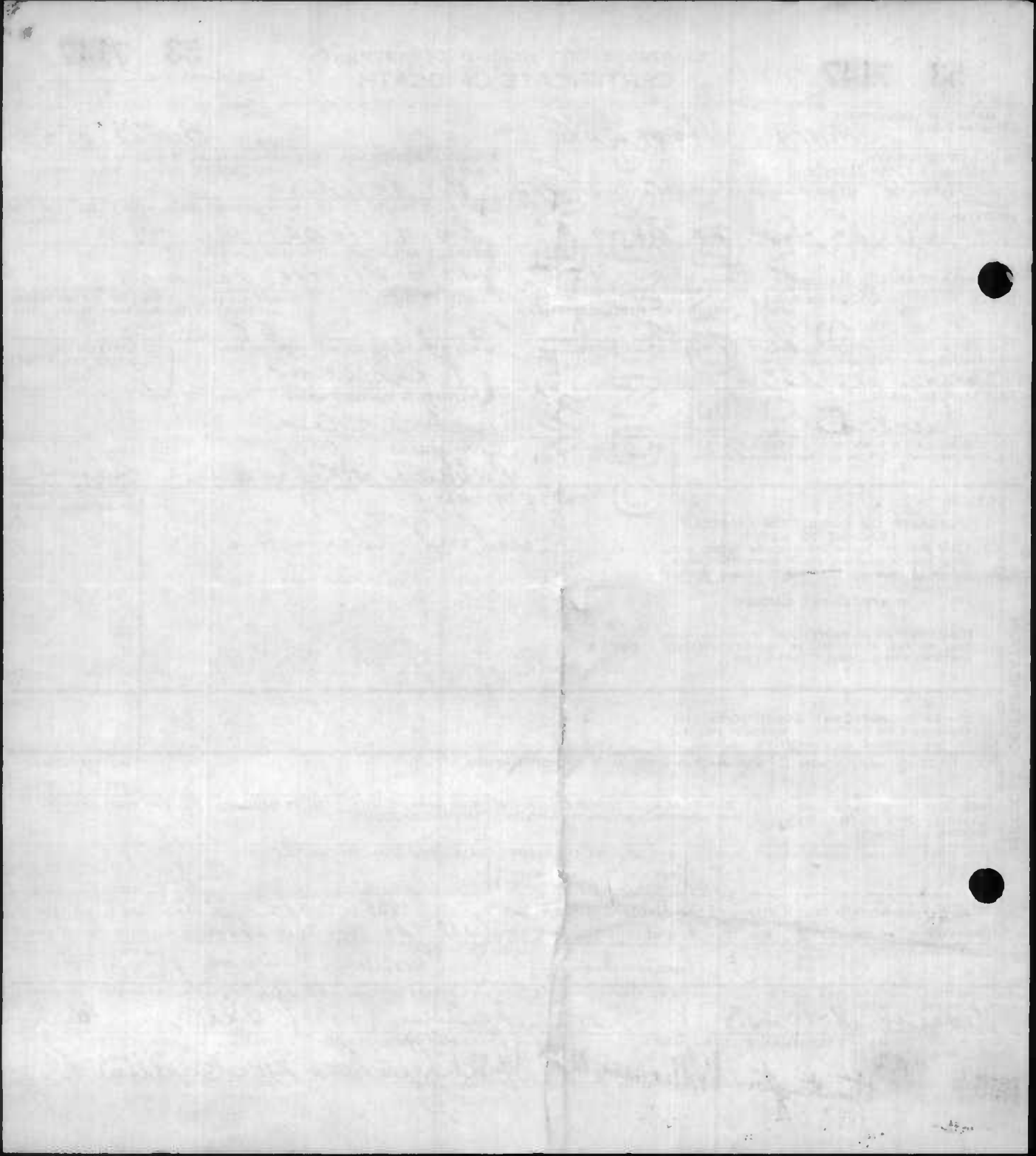
**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

53 7147  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>MARY HOFFMAN</b>				2. DATE OF DEATH <b>AUG. 9, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD MARYLAND</b> B. COUNTY _____	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSP. OF BALTO.</b>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 27-18</b>	
6. Length of stay in Baltimore <b>45</b> Yrs. <b>Days</b>				D. STREET ADDRESS (If rural, give location) <b>4717 REISTERSTOWN RD</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>	8. DATE OF BIRTH		9. AGE (In years last birthday) <b>58</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
13. FATHER'S NAME <b>Charles</b>			14. MOTHER'S MAIDEN NAME <b>Rebecca</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Nathan Hoffman - Same</b>	
18. <b>332X</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>cerebral thrombosis</b> DUE TO <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 13, 1953</b> , to <b>8/9, 1953</b> , that I last saw the deceased alive on <b>8/9, 1953</b> , and that death occurred at <b>12:30 P.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>R. Prasad</b>		23B. ADDRESS <b>Sinai Hospital, Baltimore</b>		23C. DATE SIGNED <b>8/9/53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-10-53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Rosedale</b>	
24D. LOCATION (City, town, or county) <b>Balto</b>		24E. STATE <b>Md</b>		24F. DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 9 1953</b>	
REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		F. FUNERAL DIRECTOR <b>Jack Reinecke</b>		ADDRESS <b>2100 Canton Rd</b>	

MEDICAL CERTIFICATION



A-236  
53 7148BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7148  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ESTHER AUSTRIAN

2. DATE  
OF  
DEATH

8-8-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

2806 Ullman Ave

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

2806 Ullman Ave

Length of stay in Baltimore

33

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

8. DATE OF BIRTH

9. AGE (in years last birthday) Months: Days Hours: Min.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

18. 331X I  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) ...  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ...  
DUE TO

(C) ...

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypertension and arteriosclerosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/21, 1952, to 8/8, 1953 that I last saw the deceased alive on 8/8, 1953, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

F. FUNERAL DIRECTOR

ADDRESS

150

Weyler  
Guernsey Apt



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

53 7149  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>BERTHA COPLON</b>		2. DATE OF DEATH <b>8/8/53</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland <b>SINAI HOSP.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balt.</b>	
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSP.</b>		c. CITY OR TOWN <b>Balt.</b>	
5. LENGTH OF stay in Baltimore <b>65</b> Yrs. Mos. Days		d. STREET ADDRESS (If rural, give location) <b>Riverside Apt - Lake Drive + Linden Cw</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>1873</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
13. FATHER'S NAME <b>Not Known</b>		14. MOTHER'S MAIDEN NAME <b>Not Known</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Harry Coplon - Winston Salem, N.C.</b>		ADDRESS	

18. <b>420.0</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <b>Atherosclerotic Heart Disease Chronic</b>	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO	
		(B) DUE TO	
		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>8/7</b> , 19 <b>53</b> , to <b>8/8</b> , 19 <b>53</b> that I last saw the deceased alive on <b>8/8</b> , 19 <b>53</b> and that death occurred at <b>5:20</b> m., from the causes and on the date stated above.					
23a. SIGNATURE <b>David D. Tolub</b>		23b. ADDRESS <b>SINAI HOSP.</b>		23c. DATE SIGNED <b>8/8/53</b>	

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>8/9/1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Hebrew Friendship</b>		24d. LOCATION (City, town, or county) (State) <b>Balt. Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <b>Washington Williams, M.D.</b>		FUNERAL DIRECTOR <b>John Lewis Inc - 2100 Eataw Pk</b>		ADDRESS	

MEDICAL CERTIFICATION

1903-1904 HNT 3381

J-520  
53 7150BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7150  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WARREN LEROY THOMAS

2. DATE  
OF  
DEATH

Aug. 6, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

US Public Health Service Hospital  
Woman Pk. Drive & 31st Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

419 Folsom Street

5. Length of stay in Baltimore ?

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

6/5/93

9. AGE (In years

last birthday)

60

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Engineer

10B. KIND OF BUSINESS OR INDUSTRY

Seafarer

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Thomas

14. MOTHER'S MAIDEN NAME

Wilhelmina Abbott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.  
218-05-1698

17. INFORMANT

ADDRESS

Records- U.S.PHS Hospital, Balto, Md.

18. 157X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Bronchopneumonia, secondary to

Recent

## ANTECEDENT CAUSES

DUE TO

with metastasis to

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Carcinoma of pancreas/liver and gallbladder

Several months

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 23, 1953, to Aug. 6, 1953, that I last saw the deceased alive on Aug. 6, 1953, and that death occurred at 10:10 p.m., from the causes and on the date stated above.

23A. SIGNATURE

G.E. Moffatt, Surgeon (R)

23B. ADDRESS

M. D. US PHS Hospital, Balto, Md.

23C. DATE SIGNED

8/7/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 10, 1953

24C. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cem.

24D. LOCATION (City, town, or county) (State)

Anne Arundel Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Melville Jenkins

ADDRESS

2713 Kirk Ave

AUG 9 1953

240 55

33 3120

33 3120



M-553

53 7151

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7151  
Registered No.

BIRTH NO.				1. NAME OF DECEASED (Type or Print) Catherine Minento				2. DATE OF DEATH Aug. 6 1953			
3. PLACE OF DEATH: A. Baltimore City, Maryland 919 Fawn St.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) 919 Fawn St. Balto. Md.				B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. Md. 3-02				D. STREET ADDRESS (If rural, give location) 919 Fawn St.			
C. Length of stay in Baltimore 49 yrs.				Yrs. Mos. Days							
5. SEX F.		6. COLOR OR RACE W.		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Dec. 1st. 1903 49		9. AGE (In years last birthday) 49		11 Under 1 Year Months Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Anthony Palmisano				14. MOTHER'S MAIDEN NAME Margaret Guffre							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. none				17. INFORMANT ADDRESS Mr. Rocco Minento 919 Fawn St.			
18. 421.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Acute Myocardial Infarction DUE TO Viral Pneumonia (B) Chronic Endocarditis DUE TO Myocarditis (C) Chy. cystitis				INTERVAL BETWEEN ONSET AND DEATH 6 wks. ? ?			
19A. DATE OF OPERATION				19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 11, 1953, to Aug. 6, 1953, that I last saw the deceased alive on Aug. 6, 1953, and that death occurred at 11 a.m., from the causes and on the date stated above.											
23A. SIGNATURE Mae J. Hewes				23B. ADDRESS M. D. 1000 E. Pratt St.				23C. DATE SIGNED 8/11/53			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial				24B. DATE Aug. 10 1953				24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Belair Rd. and Moravia Ave.			
24D. LOCATION (City, town, or county) Balto. Md.				24E. FUNERAL DIRECTOR Frank Della Vore				24F. ADDRESS 322 S. High St.			
DATE RECEIVED BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE							





53 7152

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7152  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mabel Dorothy Barker

2. DATE  
OF  
DEATH

8-8-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Union Memorial Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD.

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

510 E 35th ST.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

Jan 9, 1911

9. AGE (In years last birthday)

42

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Factory

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Walter Bell

14. MOTHER'S MAIDEN NAME

Maggie Off

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

same

18. 586X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) generalized Peritonitis  
+ septicemia

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Duodenal + Biliary fistulae  
(C) Common duct stricture

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Jan 21, 1953

19B. MAJOR FINDINGS OF OPERATION

Common duct stricture Biliary Cirrhosis

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23A. SIGNATURE

Louise Schramm

M. D.

23B. ADDRESS

Union Memorial Hosp

23C. DATE SIGNED

8-8-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

AUG 11/53

24C. NAME OF CEMETERY OR CREMATORY

ST. MARYS HAMPDEN

24D. LOCATION (City, town, or county)

BALTIMORE

(State)

MD.

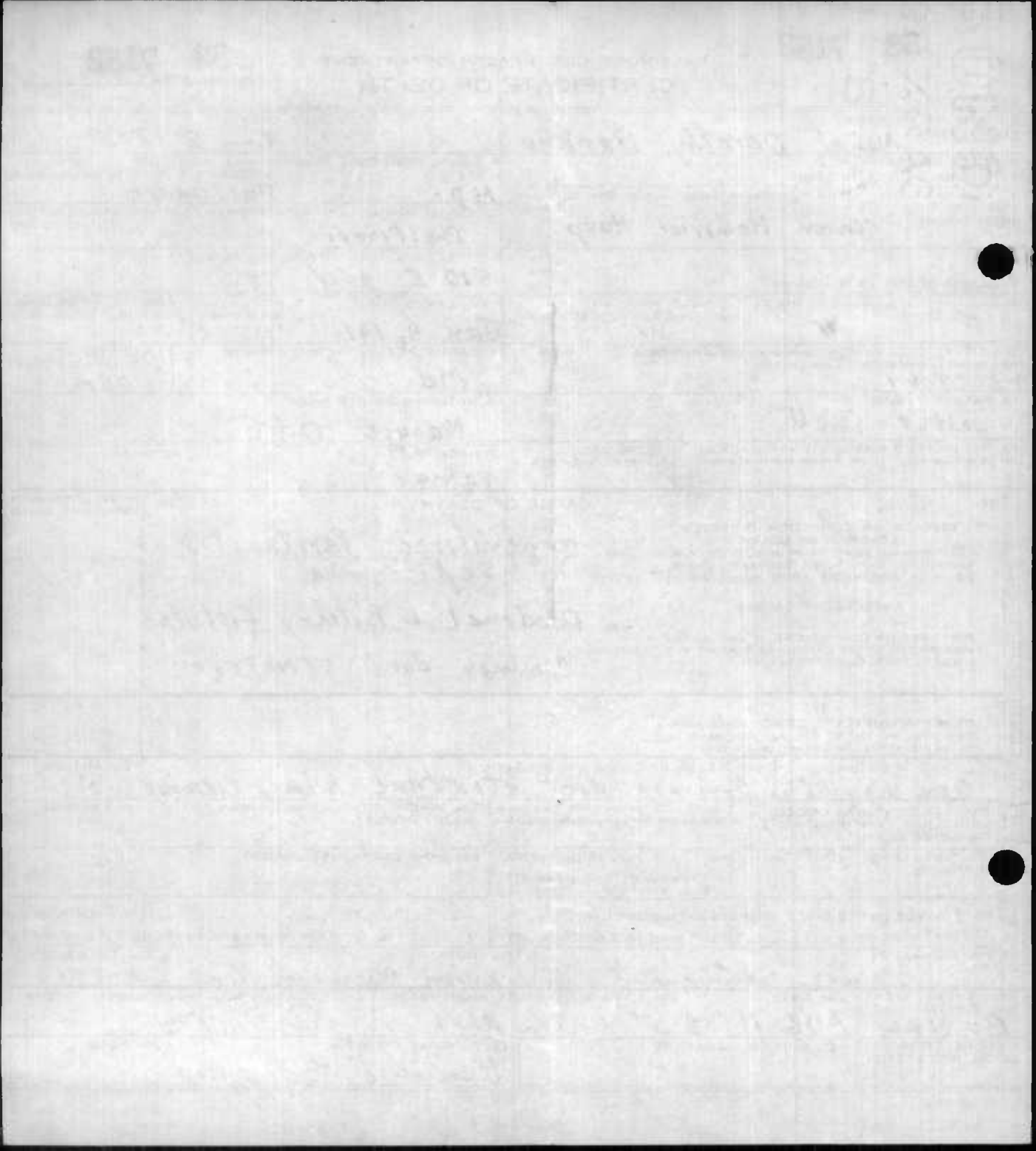
DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Kathleen P. Donovan



5-140

53 7153

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7153

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

William Oliver Shipley

2. DATE  
OF  
DEATH

8-7-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE Maryland B. COUNTY

5. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or  
location)

Union Memorial Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore 12-07

c. Length of stay in Baltimore

60

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

2902 Miles Ave.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

4-21-1893

9. AGE (In years  
last birthday)

60

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

mill worker

10B. KIND OF BUSINESS OR  
INDUSTRY

Cotton Duck Mill

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Theodore O. Shipley

14. MOTHER'S MAIDEN NAME

Mary Ellen Morrow

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

212-18-4985

17. INFORMANT

ADDRESS

John E. Shipley 2911 Miles Ave

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) cerebral vascular  
accident

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) arterio scl. Cardiovascular  
disease

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-4-1953 to 8-7-1953 that I last saw the  
deceased alive on 8-7-1953, and that death occurred at 9:15 pm., from the causes and on the date stated above.

23A. SIGNATURE

van Luth

M. D.

23B. ADDRESS

V.M.H.

23C. DATE SIGNED

8/7/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug 10-53

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

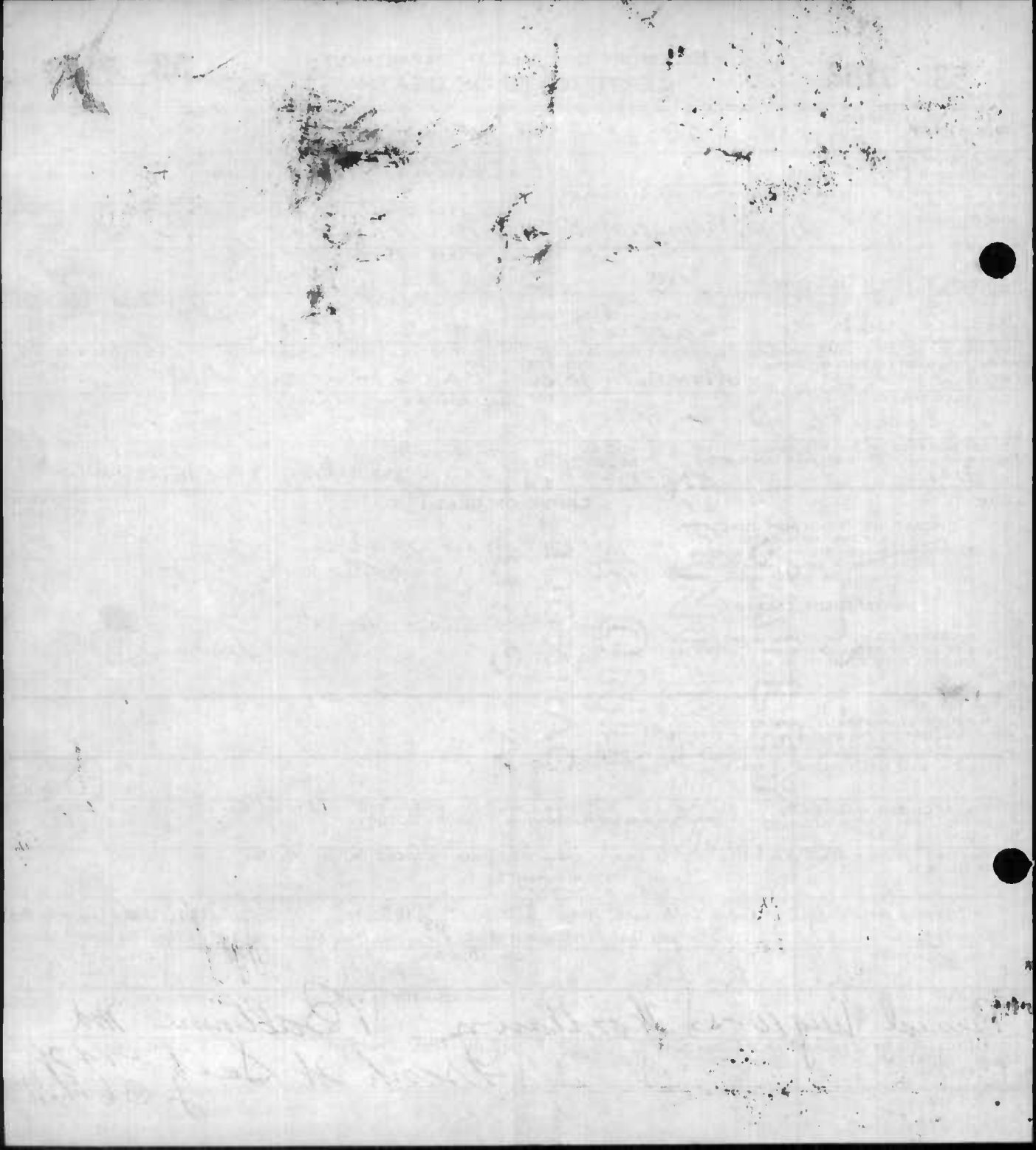
Huntington Williams

25. FUNERAL DIRECTOR

Frank J. Seitz 814 26

ADDRESS

236 N. St.



M-620

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7154

BIRTH NO. 53 7154

1. NAME OF DECEASED  
(Type or Print)

Charles Mark

2. DATE  
OF  
DEATH

August 8, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland Lutheran Hospital

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION Lutheran Hospital

430 Ashburton St. Baltimore Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore City

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 13-08

D. STREET ADDRESS (If rural, give location)

1325 W. 42nd St.

C. Length of stay in Baltimore

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

May 7, 1891

9. AGE (In years  
last birthday)

62

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

laboratory worker

10B. KIND OF BUSINESS OR  
INDUSTRY

Highland Farm Dairy, Baltimore Md.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S. A.

13. FATHER'S NAME

George Mark

14. MOTHER'S MAIDEN NAME

Mary Morris

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

216-03-9431

17. INFORMANT Hospital records ADDRESS

18. 420.0

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) acute posterior myocardial  
infarctionINTERVAL BETWEEN  
ONSET AND DEATH

16 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) chronic arteriosclerotic heart disease 3 months

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Branchopneumonia in right middle lobe 2 weeks

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 27, 1953 to August 8, 1953 that I last saw the  
deceased alive on August 8, 1953, and that death occurred at 2 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Rudolph M. Zander M.D. assistant resident

23B. ADDRESS

Lutheran Hospital Baltimore Maryland

23C. DATE SIGNED

8-8-1953

24A. BURIAL, CREMA-  
TION REMOVAL (Specify)

24B. DATE

8/11/53

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn

24D. LOCATION (City, town, or county)

Woodlawn Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Paul E. Chensmith, 3615 Chestnut Ave  
Baltimore Md

ADDRESS

095-41

MEDICAL CERTIFICATION

174

22

STATE OF NEW YORK  
IN SENATE  
JANUARY 10, 1907

REPORT  
OF THE  
COMMISSIONER OF THE LAND OFFICE

ALBANY: J.B. LIPPINCOTT & CO. PRINTERS.  
1907.

THE LAND OFFICE OF THE STATE OF NEW YORK  
HAS THE HONOR TO ACKNOWLEDGE THE RECEIPT OF  
THE FOLLOWING REPORTS FROM THE COMMISSIONERS  
OF THE LAND OFFICES OF THE SEVERAL COUNTIES  
AND TO TRANSMIT THE SAME TO THE SENATE  
AND ASSEMBLY FOR THEIR CONSIDERATION.

ALBANY, JANUARY 10, 1907.

JOHN W. ALLEN, COMMISSIONER.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7-620  
MAF-171817  
53 7165

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

53-7155  
53 7165

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Alexis Scott Towers

2. DATE  
OF  
DEATH Aug. 6, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
INSTITUTION

Baltimore City Hospitals

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

31  
c. Length of stay in Baltimore

D. STREET ADDRESS (If rural, give location)

1124 Ashland Ave. #2

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

June 30, 1875

9. AGE (In years  
last birthday)

78

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ret. Supt. Post Office

10B. KIND OF BUSINESS OR INDUSTRY

Clifton Station

11. BIRTHPLACE (State or foreign country)

Washington, D. C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William Towers

14. MOTHER'S MAIDEN NAME

Agnes Irving

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

ADDRESS

B. C. H. 4940 Eastern Ave. (records)

18. 443X and 203X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

B Generalized Arteriosclerosis

DUE TO

ANTECEDENT CAUSES

A Hypertensive Cardiovascular Disease

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Multiple Myeloma

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?  
YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-3, 1953, to 8-6, 1953, that I last saw the  
deceased alive on 8-6, 1953, and that death occurred at 11 P. m., from the causes and on the date stated above.

23A. SIGNATURE

H. J. Johnson

23B. ADDRESS

4940 Eastern Ave., Balto., Md.

23C. DATE SIGNED

8-6-1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

8/10/53

24C. NAME OF CEMETERY OR CREMATORY

Sacred Heart Cemetery

24D. LOCATION (City, town, or county)

Baltimore,

Maryland

DATE RECEIVED BY  
LOCAL REGISTRAR

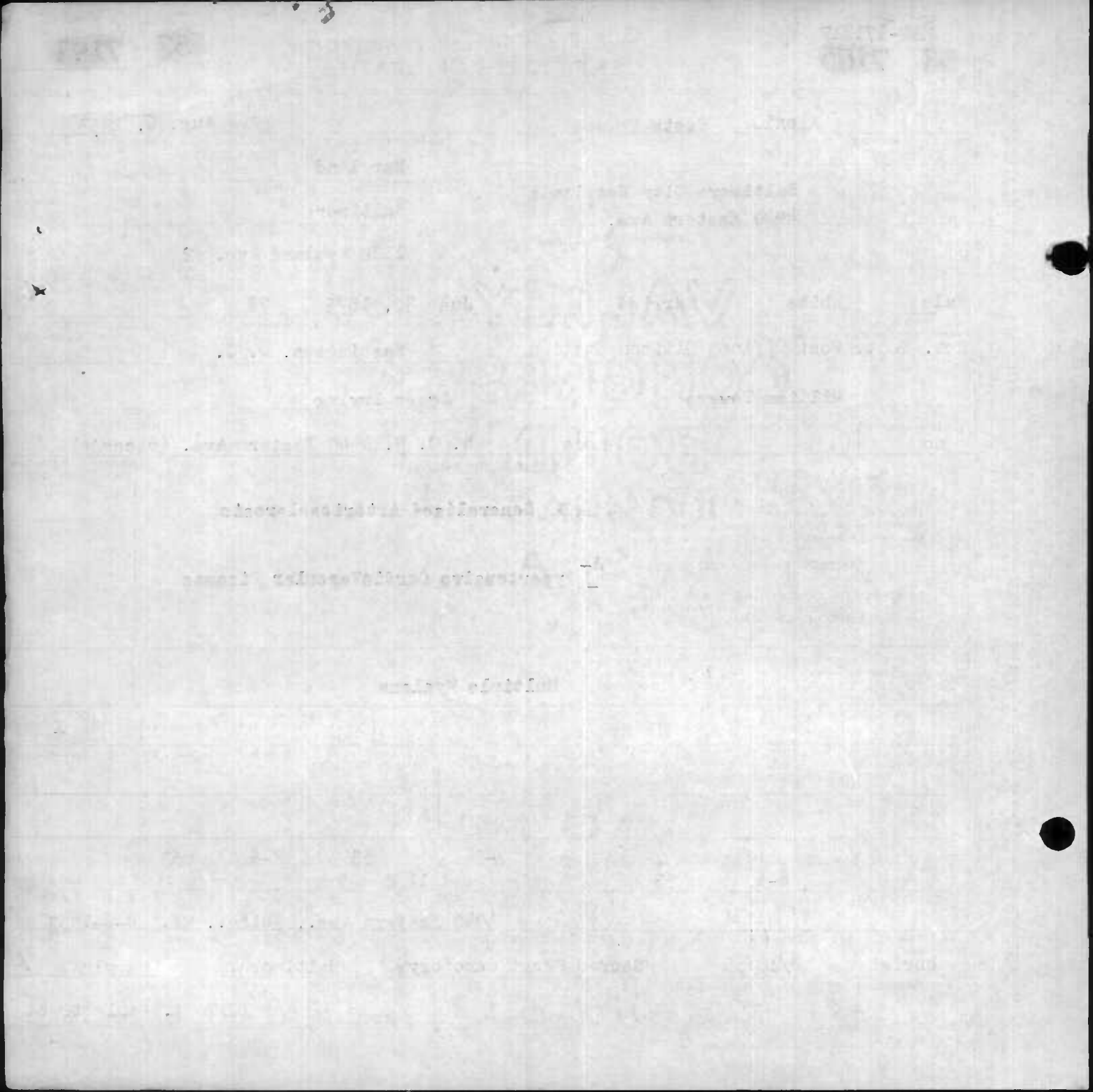
REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

ADDRESS

1217 St. Paul Street



L-200  
53 7156LEWIS  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

53 7156

7156

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Minnie B. Lewis</i>		2. DATE OF DEATH <i>Aug 8, 1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore Md.</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Home</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 14-03</i>	
Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>1830 Madison Ave</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>June 28, 1868</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, if retired) <i> Clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Insurance</i>	
13. FATHER'S NAME <i>Harry Wilson</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Dr. H. M. Williams</i>		ADDRESS <i>1201 N. C.</i>	

18. <i>260x and E903.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral</i>		CAUSE OF DEATH <i>Cerebral</i>	INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Fracture of hip</i>		CERTIFICATION APPROVED BY <i>[Signature]</i> M.D. <i>Diabetes mellitus</i>	<i>4 hrs</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<i>15 yrs</i>

19A. DATE OF OPERATION <i>July 12, 1953</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>	21C. WHERE DID INJURY OCCUR? <i>1830 Madison Ave</i>	(If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>July 12, 1953 8:30 P.M.</i>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <i>Patent fell down while washing up in bath room</i>		
22. I hereby certify that I attended the deceased from <i>July 12, 1953</i> to <i>Aug 8, 1953</i> that I last saw the deceased alive on <i>8-8</i> , 1953, and that death occurred at <i>5:30</i> m., from the causes and on the date stated above.				
23A. SIGNATURE <i>Arthur M. West</i>		23B. ADDRESS <i>1902 Edmonstone Ave</i>		23C. DATE SIGNED <i>Aug 8-9-53</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>August 12</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Arboretum</i>	24D. LOCATION (City, town, or county) (State) <i>Arboretum, Balto. Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 10 1953</i>		REGISTRAR'S SIGNATURE <i>H. H. Williams</i>		
VS 150 <i>N 820.0</i>		FUNERAL DIRECTOR <i>Severis A. Henry</i> <i>Cambridge Md.</i>		

CERTIFICATE OF DEATH

1. Name of deceased *John Doe*  
2. Age *45*  
3. Sex *Male*  
4. Date of death *Jan 15 1900*  
5. Place of death *at home*  
6. Cause of death *Heart failure*  
7. Signature of physician *J. B. Smith*  
8. Signature of registrar *W. H. Jones*  
9. Date of registration *Jan 16 1900*

10. Name of informant *John Doe*  
11. Address of informant *123 Main St*  
12. Signature of informant *J. Doe*  
13. Date of completion *Jan 16 1900*

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Joseph M. Tubman

2. DATE  
OF  
DEATH

Aug. 6/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

3809 Edmondson Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

3809 Edmondson Ave

Length of stay in Baltimore

Life

Yrs.  
Mos.  
Dnys

5. SEX

Male

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Jan. 24/08

9. AGE (In years  
last birthday)

45

If Under 1 Year Months Days  
If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Marine Engineer

10B. KIND OF BUSINESS OR INDUSTRY

Bull Line Co.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Samuel E. Tubman

14. MOTHER'S MAIDEN NAME

Estelle Bevan

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.  
415 12 1986

17. INFORMANT

ADDRESS

Mrs. Helen K. Tubman, 3809 Edmondson Ave

18. 163X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

CARCINOMA Right Lung

INTERVAL BETWEEN  
ONSET AND DEATH

7 mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 15, 1953, to Aug 6, 1953, that I last saw the deceased alive on Aug 6, 1953, and that death occurred at 4:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

3629 Edmondson Ave

8/8/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 10/53

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

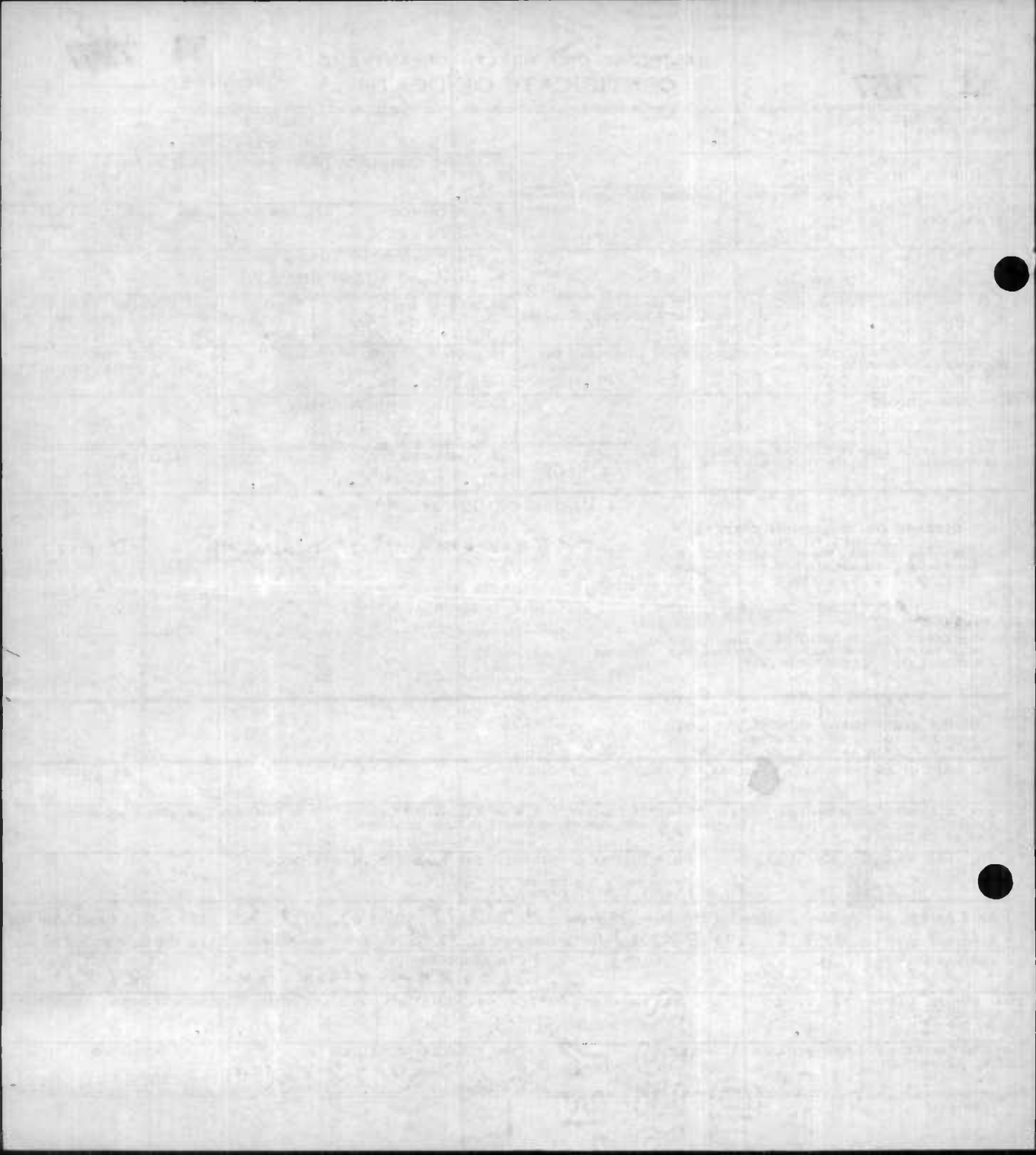
25. FUNERAL DIRECTOR

ADDRESS

AUG 10 1953

Huntington Williams, Harry Smith

4101 Edmondson Ave.





53 7158  
BIRTH NO.

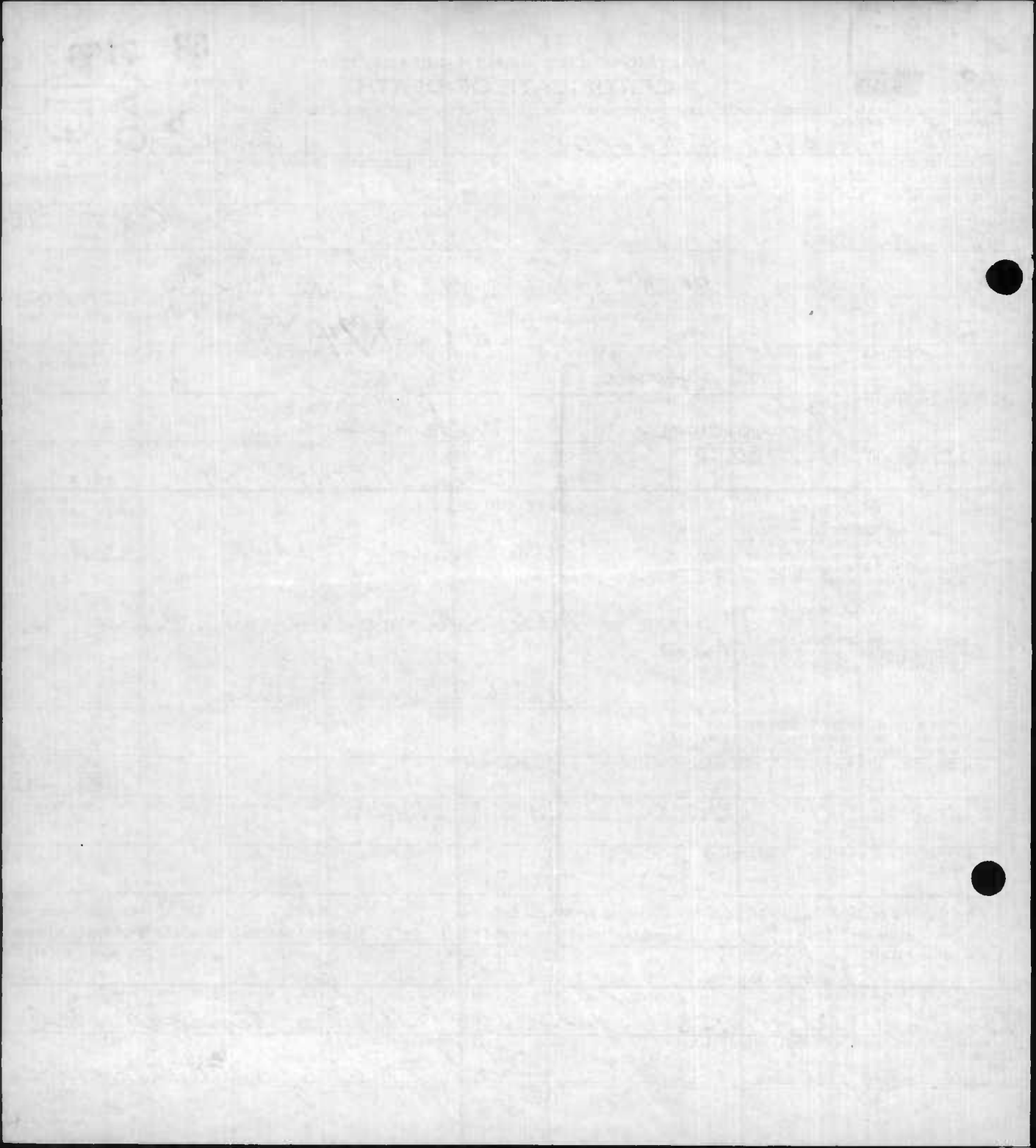
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7158  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Mrs. Agnes REINHARDT</i>			2. DATE OF DEATH <i>Aug. 7, '53</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore Maryland</i> B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Lutheran Hospital of Maryland</i> Length of stay in Baltimore <i>60 yrs.</i>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1807 Desoto Rd. #30</i>		
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>M.</i>	8. DATE OF BIRTH <i>Aug. 21, 1894</i>		9. AGE (In years last birthday) <i>72</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H.W.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>GERMANY</i>	
13. FATHER'S NAME <i>Knapp</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>William REINHARDT. SAME</i>		

18. <i>260X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
	(A) <i>Acute pulmonary edema</i>	DUE TO	<i>2 days</i>
	(B) <i>Atherosclerotic Cardio-Vascular disease</i>	DUE TO	
	(C) <i>Diabetes mellitus - Acidosis</i>		

19A. DATE OF OPERATION <i>7</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Aug 6, 1953</i> to <i>Aug 7, 1953</i> , that I last saw the deceased alive on <i>Aug 7, 1953</i> , and that death occurred at <i>7:00</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Jack &amp; E. H. H.</i>		23B. ADDRESS <i>Lutheran Hospital</i>		23C. DATE SIGNED <i>Aug 7, 53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Aug. 10/53</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Randall Pl. Baltimore, Md</i>	
24D. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR <i>Harry M. Hutzke, 4101 Edmondson</i>			
LOCAL RECEIVED BY DATE REGISTRAR <i>Aug 10 1953</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>		ADDRESS	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7159

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

53 7159

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)JOHNSON, MARY  
(MARY C. JOHNSON)2. DATE  
OF  
DEATH

Aug. 7, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF

HOSPITAL OR  
INSTITUTIONUniversity of Maryland Hospital  
(If not in hospital or institution, give street address or location)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

27-01

D. STREET ADDRESS (If rural, give location)

4112 St. Thomas Ave.

E. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

11-10-88

9. AGE (In years,  
last birthday)

65

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

---

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Rosenthal

14. MOTHER'S MAIDEN NAME

Margaret Tillman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT F. Johnson (Husband)  
4112 St. Thomas Ave.

18. 159X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) .....

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) .....

DUE TO

(C) .....

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

May 1953

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

Acute Abdomen

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH. ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 3, 1953, to Aug. 7, 1953, that I last saw the  
deceased alive on Aug. 7, 1953, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Sadhin M. M. D.

23B. ADDRESS

University Hospital

23C. DATE SIGNED

8/7/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 10. 1953

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cem.

24D. LOCATION (City, town, or county)

Baltimore Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

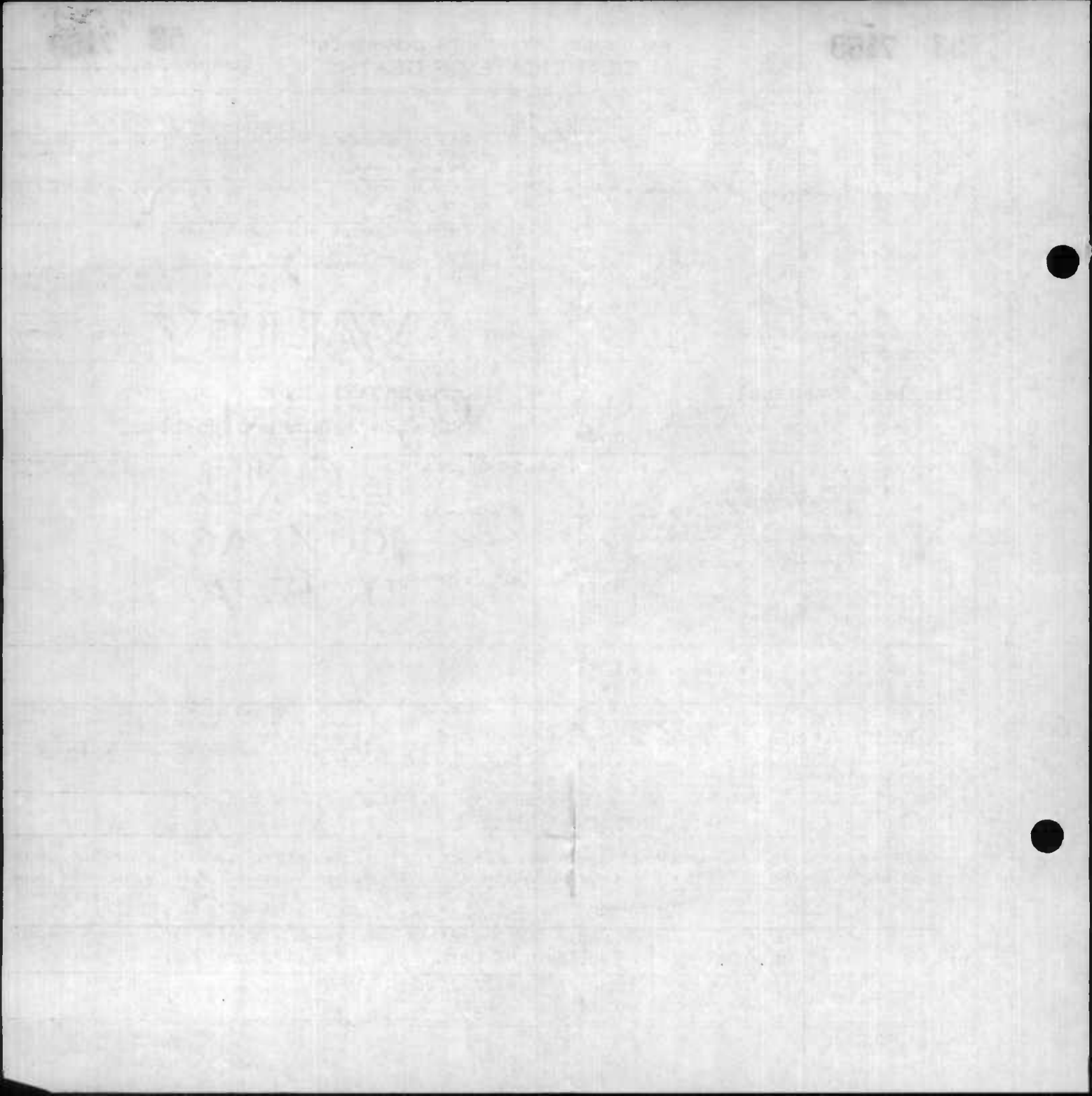
25. FUNERAL DIRECTOR

HENRY SANDER & SONS, INC.  
Baltimore Md.

ADDRESS

AUG 13 1953

Sgt. F. M. M.



540  
53 7160

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7160  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (WILLIAM STEWART O'NEIL) WILLIAM S. O'NEIL		2. DATE OF DEATH August 7, 1953	
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore, Md.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
B. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-06			
Length of stay in Baltimore 65 YRS.		D. STREET ADDRESS (If rural, give location) 1633 N. Wolfe St., Balto. 13, Md.			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 15, 1884	9. AGE (In years last birthday) 69	10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER retired 4yr. Md. Color Printing Company		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John O'Neill		14. MOTHER'S MAIDEN NAME Maggie C. Richardson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 215-01-7553		17. INFORMANT Elsie Morgan O'Neill (Wife) 1633 N. Wolfe St.	
18. 450.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO Generalize Arteriosclerosis with schrotic gangrene of left four toes		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Aug. 2, 1953, to August 7, 1953, that I last saw the deceased alive on Aug. 7, 1953, and that death occurred at 7:30 Pm., from the causes and on the date stated above.					
23A. SIGNATURE Pelagio E. Layung		23B. ADDRESS 1400 N. Caroline St., Balto. 13, Md.		23C. DATE SIGNED 8/7/53	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 10, 1953		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	
24D. LOCATION (City, town, or county) Baltimore Md.		24E. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		24F. LOCATION (City, town, or county) Baltimore Md.	
DATE RECEIVED BY LOCAL REGISTRAR AUG 10 1953		REGISTRAR'S SIGNATURE Huntington Williams		25. FUNERAL DIRECTOR & SONS, INC. Baltimore Md.	

MEDICAL CERTIFICATION

5124M

Gray P. Parker

0000

8

DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

0000





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

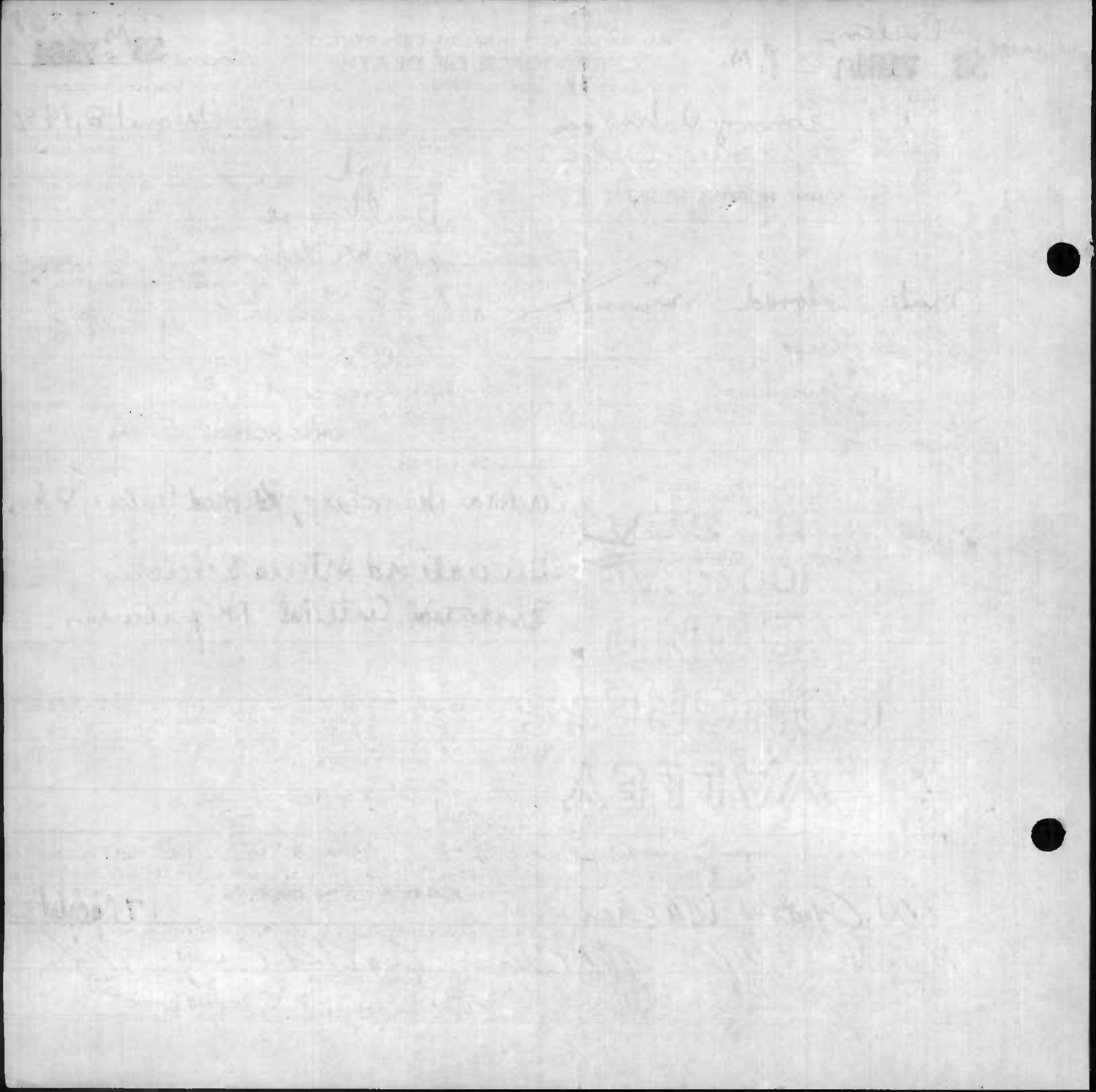
Registered No.

P.M. 7161  
7161

1. NAME OF DECEASED (Type or Print) <b>Emory Johnson</b>		2. DATE OF DEATH <b>August 6, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Med - Oples 2</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 11-04</b> D. STREET ADDRESS (If rural, give location) <b>316 W. Hoffman St.</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>		E. AGE (In years last birthday) <b>46</b> F. Under 1 Year Months: Days: Hours: Min.	
c. Length of stay in Baltimore <b>33</b>		G. DATE OF BIRTH <b>7-28-07</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>7-28-07</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>JOHNS HOPKINS HOSPITAL</b>		ADDRESS	
18. <b>331X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Hemorrhage, Rt. Mid. Cerebral 8 hrs</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Generalized Arterio Sclerosis</b> <b>Essential Arterial Hypertension</b>		DUE TO	
II OTHER SIGNIFICANT CONITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>7</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>8-6</b> 1953, to <b>8-6</b> 1953, that I last saw the deceased alive on <b>8-6</b> 1953, and that death occurred at <b>9:30</b> p.m., from the causes and on the date stated above.			
23A. SIGNATURE <b>W. Gordon Walker</b> M.D.		23B. <b>JOHNS HOPKINS HOSPITAL</b>	
23C. DATE SIGNED <b>7 August 53</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/11/53</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>St. Calvary Cem. D.C. County</b>		24D. LOCATION (City, town, or county) (State) <b>MD</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>August 10 1953</b>		REGISTRAR'S SIGNATURE <b>William Jackson</b>	
25. FUNERAL DIRECTOR <b>William Jackson</b>		ADDRESS	

AUG 10 1953  
VS 150

6A352



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **53 7162**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

**Lambert, Frank Raymond Sr.**

2. DATE  
OF  
DEATH

**August 7, 1953**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

**St. Joseph's Hospital**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

**Maryland**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**Baltimore**

D. STREET ADDRESS (If rural, give location)

**518 Middle River Road**

5. SEX

**Male**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

**Widowed**

8. DATE OF BIRTH

**Dec. 12 - 1890**

9. AGE (In years  
last birthday)

**62**

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of worklog life, even if retired)

**Retired railroader**

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Maryland**

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

**Unknown**

14. MOTHER'S MAIDEN NAME

**Unknown**

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

**Mrs Ella Hanna (daughter)**

18. **450.0**

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) **Uremia**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) **Arteriosclerosis, generalized**

DUE TO

(C) **Cardiac failure**

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from **August 6**, 1953 to **August 7**, 1953, that I last saw the  
deceased alive on **August 7**, 1953, and that death occurred at **5:04 a.m.**, from the causes and on the date stated above.

23A. SIGNATURE

**Nathanial D. Santiago**

M. D.

23B. ADDRESS

**1400 N. Caroline Street**

23C. DATE SIGNED

**August 7, 1953**

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

**Burial**

24B. DATE

**Aug. 10 - 1953**

24C. NAME OF CEMETERY OR CREMATORY

**Schwartz Cem.**

24D. LOCATION (City, town, or county)

**Balto Md.**

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**Huntington Williams**

25. FUNERAL DIRECTOR

**John G. Connolly**

ADDRESS

**Essex**

1985

1985

RECEIVED  
OFFICE OF THE  
ATTORNEY GENERAL  
STATE OF NEW YORK

1985

1985

IN SENATE  
JANUARY 15, 1985

REPORT OF THE  
COMMISSIONER OF THE  
DEPARTMENT OF SOCIAL SERVICES

ON THE  
ADMINISTRATIVE AND FINANCIAL  
OPERATIONS OF THE DEPARTMENT

FOR THE FISCAL YEAR  
ENDING DECEMBER 31, 1984

AS SUBMITTED TO THE  
COMMISSIONER OF THE DEPARTMENT

AND THE JOINT  
LEGISLATIVE COMMITTEE ON  
GOVERNMENT OPERATIONS

IN RESPONSE TO A  
RESOLUTION PASSED BY THE  
SENATE ON JUNE 12, 1984

AND A RESOLUTION PASSED BY THE  
ASSEMBLY ON JUNE 12, 1984

AND A RESOLUTION PASSED BY THE  
SENATE ON JUNE 12, 1984

AND A RESOLUTION PASSED BY THE  
ASSEMBLY ON JUNE 12, 1984

AND A RESOLUTION PASSED BY THE  
SENATE ON JUNE 12, 1984

AND A RESOLUTION PASSED BY THE  
ASSEMBLY ON JUNE 12, 1984

AND A RESOLUTION PASSED BY THE  
SENATE ON JUNE 12, 1984

AND A RESOLUTION PASSED BY THE  
ASSEMBLY ON JUNE 12, 1984

AND A RESOLUTION PASSED BY THE  
SENATE ON JUNE 12, 1984

AND A RESOLUTION PASSED BY THE  
ASSEMBLY ON JUNE 12, 1984

AND A RESOLUTION PASSED BY THE  
SENATE ON JUNE 12, 1984

AND A RESOLUTION PASSED BY THE  
ASSEMBLY ON JUNE 12, 1984

M-200

53 7168

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7168

1. NAME OF DECEASED (Type or Print) <b>HARRY W. MEUSHAW</b>		2. DATE OF DEATH <b>August 8, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>715 McCABE AVE</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE</b>	
D. STREET ADDRESS (If rural, give location) <b>715 McCABE AVE</b>		E. LENGTH OF STAY IN BALTIMORE <b>58 yrs</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>2-28-1871</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bridge Engineer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>BALTIMORE CITY</b>	9. AGE (in years last birthday) <b>82</b>
13. FATHER'S NAME <b>John Meushaw</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mrs. Myrtle Bruno</b>		ADDRESS	

18. <b>199.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cancer of the left side of the neck and jaw</b>		INTERVAL BETWEEN ONSET AND DEATH
CAUSE OF DEATH (A) <b>Cancer of the left side of the neck and jaw</b> DUE TO		
(B) <b>Anemia</b> DUE TO		
(C)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Nov 1, 1953</b> to <b>Aug 8, 1953</b> , that I last saw the deceased alive on <b>Aug 8, 1953</b> , and that death occurred at <b>5:30 p.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Manuel Sodaro</b>		23B. ADDRESS <b>4624 York Road</b>		23C. DATE SIGNED <b>Aug 9-53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-11-1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Woodlawn</b>		24E. STATE <b>MD</b>		25. FUNERAL DIRECTOR <b>Glenn J. Day</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 10 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>		ADDRESS <b>75209 York Rd</b>	

MEDICAL CERTIFICATION





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7164  
Registered No.

53 7164  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Mrs Grace Schminke</i>		2. DATE OF DEATH <i>8-7-1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>124 Clyde Ave - Lansdowne</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>St Agnes Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Lansdowne, Md</i>	
D. STREET ADDRESS (If rural, give location) <i>124 Clyde Ave. 5351</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>m</i>		8. DATE OF BIRTH <i>Jan 17-1897</i>	
9. AGE (In years last birthday) <i>56 yrs</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
11. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Henry Schminke</i>		14. MOTHER'S MAIDEN NAME <i>Sarah J Shaw</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Victor E Schminke</i>		ADDRESS <i>124 Clyde Ave</i>	

18. <i>584X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Diffuse venous mesenteric thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Thrombosis of portal vein</i>		
DUE TO		
(C) <i>Cholelithiasis</i>		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>Aug 7</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Aug 7</i> , 19 <i>53</i> , to <i>Aug 7</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>Aug 7</i> , 19 <i>53</i> , and that death occurred at <i>8:15P</i> m., from the causes and on the date stated above.			
23A. SIGNATURE <i>James E Rowe Jr.</i>		23B. ADDRESS <i>St Agnes Hosp.</i>	
23C. DATE SIGNED <i>8/8/53</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Aug 11-1953</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>St Natl</i>		24D. LOCATION (City, town, or county) (State) <i>Balto Md</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 10 1953</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>	
FUNERAL DIRECTOR <i>Wm Cook Inc</i>		ADDRESS <i>1217 St Paul St</i>	

MAY 50

MAY 50

M. 252

53 7165

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7165

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MAS CLARA MACKENZIE

2. DATE  
OF  
DEATH

8/9/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

Mary Hospital, Inc.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Towson

D. STREET ADDRESS (If rural, give location)

Cubbell Rd.

C. Length of stay in Baltimore

39 Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)10 Under 1 Year  
Months Days11 Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Miss Mary Sprawl 740 E. Market St  
Baltimore, Md.

18. 155X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Carcinomatous

INTERVAL BETWEEN  
ONSET AND DEATH

Over 6 mo.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Carcinoma of Zell Bladder

Over 6 mo.

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from 8/1/53, to 8/9, 1953 that I last saw the  
deceased alive on 8/9, 1953 and that death occurred at 12:34 Pm., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 10 1953

Huntington Williams

Lassaline Funeral Home 740 E. Baltimore

7108

DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

7108

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

INTERMEDIATE CAUSE

PRE-EXISTING DISEASE

PRE-EXISTING INJURY

PRE-EXISTING WEAKNESS

PRE-EXISTING DEFECT

PRE-EXISTING DISORDER

PRE-EXISTING CONDITION

PRE-EXISTING STATE

PRE-EXISTING SITUATION

PRE-EXISTING CIRCUMSTANCE

H-412

53 7166

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7166  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>AUGUST HLAFA</i>		2. DATE OF DEATH <i>AUGUST 9, 1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>SOUTH BALTO. GEN. HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>BALTIMORE 21-02</i>			
Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>866 CARROLL ST.</i>			
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>3/19/1887</i>	9. AGE (In years last birthday) <i>66</i>	10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none at all</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>JOSEPH HLAFA</i>		14. MOTHER'S MAIDEN NAME <i>MARIE BECLAR</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mrs. Anna O'Neal 866 Carroll St.</i>	
18. <i>330X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>ENCEPHALOPATHY</i> DUE TO <i>weeks</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Sub-arachnoid hemorrhage weeks</i> <i>Generalized arteriosclerosis years</i>		DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Bilateral pneumonitis</i> <i>days</i>					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>7-4-1953</i> to <i>8-9-1953</i> that I last saw the deceased alive on <i>8-9-1953</i> and that death occurred at <i>4:25 p.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Ronald Benveniste</i>		23B. ADDRESS <i>South Balto. Heights</i>		23C. DATE SIGNED <i>8-9-53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/12/53</i>		24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>4370 Old Frederick Rd.</i>		25. FUNERAL DIRECTOR <i>Huntington Hillman</i>		ADDRESS <i>John J. Bowman &amp; Son 1401 Hollins St.</i>	





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. **53 7167**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Charles Threadgill</b>		2. DATE OF DEATH <b>Aug. 6, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived in institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>1113 Park Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <b>Baltimore 11-02</b>			
c. Length of stay in Baltimore <b>30 yrs.</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>1113 Park Ave.</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 3, 1905</b>	9. AGE (In years, last birthday) <b>48</b>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Steel Plant</b>		11. BIRTHPLACE (State or foreign country) <b>Ansonville, N.C.</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Calvin Allen</b>		14. MOTHER'S MAIDEN NAME <b>Eura Medley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. PRESENT ADDRESS <b>1209A Preetman St.</b>	
18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive P. V. Disease</b>		CAUSE OF DEATH (A) <b>Hypertensive P. V. Disease</b> DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>8-5-53</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <b>7-6-53</b> to <b>8-6-53</b> that I last saw the deceased alive on <b>8-5-53</b> and that death occurred at <b>7:45 Am.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Circial P. Smith</b>		23B. ADDRESS <b>1209 Gwynn Falls Pkwy</b>		23C. DATE SIGNED <b>8-10-53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 11, 1953</b>		24C. NAME OF CEMETERY OR CREMATOR <b>Baptist Church</b>	
24D. LOCATION (City, town, or county) (State) <b>Ansonville, N.C.</b>		DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 10 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>	
25. FUNERAL DIRECTOR <b>Funeral Home</b>		26. ADDRESS <b>1651 Duval Hill Ave.</b>			

1915

1915



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-200  
53 7168BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7168

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>REBECCA SKINNER WISE</b>			2. DATE OF DEATH <b>August 9, 1953</b>		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>none</b>		
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>Long Green Nursing Home</b> <b>115 E. Melrose Avenue</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore <b>60</b> Yrs. <b>46</b> Mos. <b>5</b> Days			d. STREET ADDRESS (If rural, give location) <b>113 Hawthorne Road</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>April 12, 1875</b>	9. AGE (In years last birthday) <b>78</b>	10. Under 1 Year Months: Days: Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Terminal shipping company</b>		11. BIRTHPLACE (State or foreign country) <b>Queen Anne County, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>Md.</b>			13. FATHER'S NAME <b>Samuel Skinner</b>		
14. MOTHER'S MAIDEN NAME <b>Alverta Legge</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <b>G. Douglas Wise 326 Woodlawn Road</b>		
18. <b>331X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Hemorrhage</b> DUE TO <b>(A)</b>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(B)</b> <b>Vascular Hypertension</b> DUE TO <b>(C)</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Arterial Sclerosis</b>					
19a. DATE OF OPERATION <b>0</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <b>June 15, 1953</b> , to <b>Aug 8, 1953</b> , that I last saw the deceased alive on <b>8-9-53</b> , and that death occurred at <b>3:10 A.M.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Huntington Williams</b>		23b. ADDRESS <b>1123 St. Paul St.</b>		23c. DATE SIGNED <b>8 - 10 - 53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>8 - 11 - 53</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>	
24d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25. FUNERAL DIRECTOR <b>John P. Mitchell &amp; Sons, Inc.</b>		ADDRESS <b>1900 Eutaw Place</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 10 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>		26. SIGNATURE <b>M B Mitchell</b>	

23 1985

23 1985

53 7169

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7169

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

THELMA

DAVIS

2. DATE  
OF  
DEATH

August 6, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Baltimore City Morgue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1609 W. Fayette Street

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

6/10/1926

9. AGE (In years last birthday)

27

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

DOMESTIC

11. BIRTHPLACE (State or foreign country)

MERRITT, N.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JAMES THOMPSON

14. MOTHER'S MAIDEN NAME

ANNA JONES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

EDWARD EARL DAVIS(H) 1609 W. FAYETT

18.

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic heart disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....

23C. DATE SIGNED

M.D. ASSISTANT MEDICAL EXAMINER.....

August 6, 1953

MEDICAL INVESTIGATOR.....

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

8/10/53

24C. NAME OF CEMETERY OR CREMATORY

BALTO. NAT'L. CEMETERY, BALTO. MD.

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

V S 151

7208A

572 Carrollton av.

28 7889

28 7889

EX-100000

DATE

U.S.A.

NEW YORK, N.Y.

DEPARTED

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NEW YORK

NEW YORK

HOWARD MARY BATHING AND SWIMMING

NO

U.S. DEPARTMENT OF COMMERCE, BUREAU OF MARITIME SERVICE

U.S. DEPARTMENT OF COMMERCE, BUREAU OF MARITIME SERVICE



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

53 7170  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Frank Vopallecky</b>			2. DATE OF DEATH <b>August 8, 1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph's Hospital</b> <b>1400 N. Caroline St.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
D. LENGTH OF STAY IN BALTIMORE Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>2021 Sparks Court</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>Jan. 1902</b>		9. AGE (in years, last birthday) <b>51</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumbers Helper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Frank Vopalecky</b>			14. MOTHER'S MAIDEN NAME <b>Anna Prokop</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-05-9350</b>	17. INFORMANT ADDRESS <b>Caspar Vopolecky, 425 Madeira St 5</b>		

18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> (A) _____ DUE TO _____		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arteriosclerotic Cardiovascular Disease</b> (B) _____ DUE TO _____ (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 29</b> , 1953, to <b>August 8</b> , 1953, that I last saw the deceased alive on <b>August 8, 1953</b> , and that death occurred at <b>7:45 PM</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>R. Cassinelli</b>		23B. ADDRESS		23C. DATE SIGNED	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-12-1953</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 10 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		25. FUNERAL DIRECTOR ADDRESS <b>Fr. Cragh &amp; Son, 900 N. Chester St. 5</b>



-263  
53 7171

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7171

1. NAME OF DECEASED (Type or Print) <b>MORTON McI. DUKEHART</b>		2. DATE OF DEATH <b>8/8/53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSP.</b>		C. CITY OR TOWN (If outside corporate limits, write full name and give township) <b>BALTIMORE-10 27-14</b>	
c. Length of stay in Baltimore <b>LIFE</b>		D. STREET ADDRESS (If rural, give location) <b>419 WOODLAWN AVE. RD.</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>	8. DATE OF BIRTH <b>3/15/1879</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>? PRESIDENT</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SALES ENGINEERING</b>	
13. FATHER'S NAME <b>THOMAS DUKEHART</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>? No</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>WIFE (MABEL C. DUKEHART)</b>		ADDRESS <b>SAME</b>	
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarction</b> DUE TO <b>arteriosclerotic cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>?</b>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>8</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) INJURY <b>8/7/53</b>	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>8/7/53</b> , 19__, to <b>8/8/53</b> , 19__, that I last saw the deceased alive on <b>8/8/53</b> , 19__, and that death occurred at <b>4:15 P.m.</b> , from the causes and on the date stated above.			
23. SIGNATURE <b>Henry L. Knock, Jr.</b>		23B. ADDRESS <b>Union Memorial Hosp.</b>	
23C. DATE SIGNED <b>8/8/53</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-11-53</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>SHREWSBURY CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>KENNEDYVILLE MD.</b>	
25. FUNERAL DIRECTOR <b>Huntington W. Bland, M.D.</b>		ADDRESS <b>Q. Tucker &amp; Sons Inc. Balto md</b>	

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

11-1-1918

Name of Deceased		John Doe	
Age		45	
Sex		Male	
Race		White	
Date of Death		11-1-1918	
Place of Death		Home	
Cause of Death		Heart Disease	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Signature of Coroner		[Signature]	
Signature of Burial Officer		[Signature]	
Signature of Undertaker		[Signature]	
Signature of Minister		[Signature]	
Signature of Priest		[Signature]	
Signature of Rabbi		[Signature]	
Signature of Imam		[Signature]	
Signature of Other		[Signature]	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **53 7172**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print) **VANSCOY, DARLENE**

2. DATE OF DEATH **8/10/53**

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **WEST VIRGINIA** B. COUNTY **V-45**

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
INSTITUTION **University Hospital**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**BRIDGEPORT**

C. Length of stay in Baltimore **12**

D. STREET ADDRESS (If rural, give location)  
**CHURCH ST.**

5. SEX **F**

6. COLOR OR RACE **W**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **S**

8. DATE OF BIRTH **7/28/44**

9. AGE (In years last birthday) **9 yr**  
If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
**STUDENT**

10B. KIND OF BUSINESS OR INDUSTRY **—**

11. BIRTHPLACE (State or foreign country)  
**W. Va. Harrison Co.**

12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME

**HAROLD VANSOY**

14. MOTHER'S MAIDEN NAME

**RUBY MAULLER**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) **No** (If yes, give war or dates of service) **—**

16. SOCIAL SECURITY NO. **—**

17. INFORMANT **FATHER.** ADDRESS **W. Va. HAROLD VANSOY - CHURCH ST. BRIDGEPORT,**

18. **592X**  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
**Chronic glomerulonephritis**

(A) DUE TO

INTERVAL BETWEEN ONSET AND DEATH **6 months**

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

**G.I. hemorrhage**

**3 days**

19A. DATE OF OPERATION **—**

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED **—**

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7/29**, 19**53**, to **8/10**, 19**53**, that I last saw the deceased alive on **8/10**, 19**53**, and that death occurred at **4:25** a. m., from the causes and on the date stated above.

23A. SIGNATURE

**Georgia Reynolds**

23B. ADDRESS

**University Hospital**

23C. DATE SIGNED

**8/10/53**

24A. BURIAL, CREMATION, REMOVAL (Specify)  
**REMOVAL**

24B. DATE **8-10-53**

24C. NAME OF CEMETERY OR CREMATORY **?**

24D. LOCATION (City, town, or county) **CLARKSBURG, W. Va**

(State)

DATE RECEIVED BY LOCAL REGISTRAR

**AUG 10 1953**

REGISTRAR'S SIGNATURE

**Huntington Williams, M.D.**

25. FUNERAL DIRECTOR

**Mr. J. L. Tucker and Bartlett, Bridgeport, W. Va.**

ADDRESS

SN 17

SN 17

W. H. HAW  
22120000

10000000

10000000

10000000



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

53

7178

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

INEZ

VICTORY

2. DATE  
OF DEATH August 10, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

B. FULL NAME OF (not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE University HospitalC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

3115 Baker Street

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

March 3, 1922

9. AGE (in years last birthday)

31

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Accomack County, VA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Rayfield

14. MOTHER'S MAIDEN NAME

Catherine Poulson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Edward Rayfield,

ADDRESS

Onancock, VA

18. 456x

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Disseminated Lupus Erythematosus

XXXXX

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an inspection & inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William H. Brown

M.D.

23B. CHIEF MEDICAL EXAMINER.....☒  
ASSISTANT MEDICAL EXAMINER.....☒

23C. DATE SIGNED

8-10-53

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

August 1953

24C. NAME OF CEMETERY OR CREMATORY

Bayside Cemetery

24D. LOCATION (City, town, or county)

Onancock, R.F.D.

(State)

VA

DATE RECEIVED BY LOCAL REGISTRAR

AUG 10 1953

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

J. Edgar Thomas

ADDRESS

Accomack, VA



M-600

7174

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7174

1. NAME OF DECEASED (Type or Print) <b>WILLIAM MEIER</b>		2. DATE OF DEATH <b>AUG. 7. 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>3718 CLAREMONT</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>26-08</b>	
C. Length of stay in Baltimore <b>42 YRS</b>		D. STREET ADDRESS (If rural, give location) <b>3718 CLAREMONT AVE</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>AUG 20, 1899</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OFFICE CLERK</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>ANCHOR FENCE CO.</b>	9. AGE (In years last birthday) <b>53</b>
13. FATHER'S NAME <b>LUDWIG MEIER</b>		12. CITIZEN OF WHAT COUNTRY? <b>GERMANY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO.</b>		14. MOTHER'S MAIDEN NAME <b>ROSINE MILLER</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>MRS LENA MEIER 3718 CLAREMONT</b>	
18. <b>157X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cancer head of Pancreas</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO	
19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION <b>Cancer head of Pancreas</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7-27</b> , 19 <b>53</b> to <b>Aug. 7</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>Aug. 7</b> , 19 <b>53</b> and that death occurred at <b>7:40 P.m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>J. N. Lasker</b>	23B. ADDRESS <b>637 S. Conkling St</b>	23C. DATE SIGNED <b>8-17-53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>AUG 10 1953</b>	24C. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>	24D. LOCATION (City, town, or county) (State) <b>COLGATE MD</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 10 1953</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams</b>	25. FUNERAL DIRECTOR ADDRESS <b>4210 ULURICH FUNERAL HOME BELAIR.</b>	

3903D

MEDICAL CERTIFICATION

1951

1952

1953

1954



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7175

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7175

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

AUGUST F. FENKER

2. DATE  
OF  
DEATH

8/9/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Maryland Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

University Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 27-03

c. Length of stay in Baltimore

D. STREET ADDRESS (If rural, give location)

5108 Harford Rd.

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

4/29/92

9. AGE (In years  
last birthday)

61

10. Under 1 Year 11. Under 24 Hours  
Months Days Hours Min.

10a. CAUSE OF DEATH (Give kind of  
work should not be omitted, even if feared)

Retired

10b. KIND OF BUSINESS OR  
INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

AUGUST G. FENKER

14. MOTHER'S MAIDEN NAME

SOPHIA MICHAELIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS 5108

MRS MADE FENKER HARFORD RD

18. 578X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Intestinal Obstruction 48 hrs

ANTECEDENT CAUSES

(B)

DUE TO

adhesions

(C)

Peritonitis 9 days

Rupture of colon

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Shock Secondary to operation

19a. DATE OF OPERATION

7/31 and 8/8

19b. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

Perforation of colon + Int. abs.

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?  
YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)

21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/3, 1953, to 8/9, 1953 that I last saw the  
deceased alive on 8/9, 1953, and that death occurred at 9:25 AM, from the causes and on the date stated above.

23a. SIGNATURE

John B. Codrington

23b. ADDRESS

University Hosp.

23c. DATE SIGNED

8/9/53

24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24b. DATE

AUG 13, 1953

24c. NAME OF CEMETERY OR CREMATORY

LORRAINE

24d. LOCATION (City, town, or county)

WOOD LAWN MD

DATE RECEIVED BY  
LOCAL REGISTRAR

AUG 10 1953

REGISTRAR'S SIGNATURE

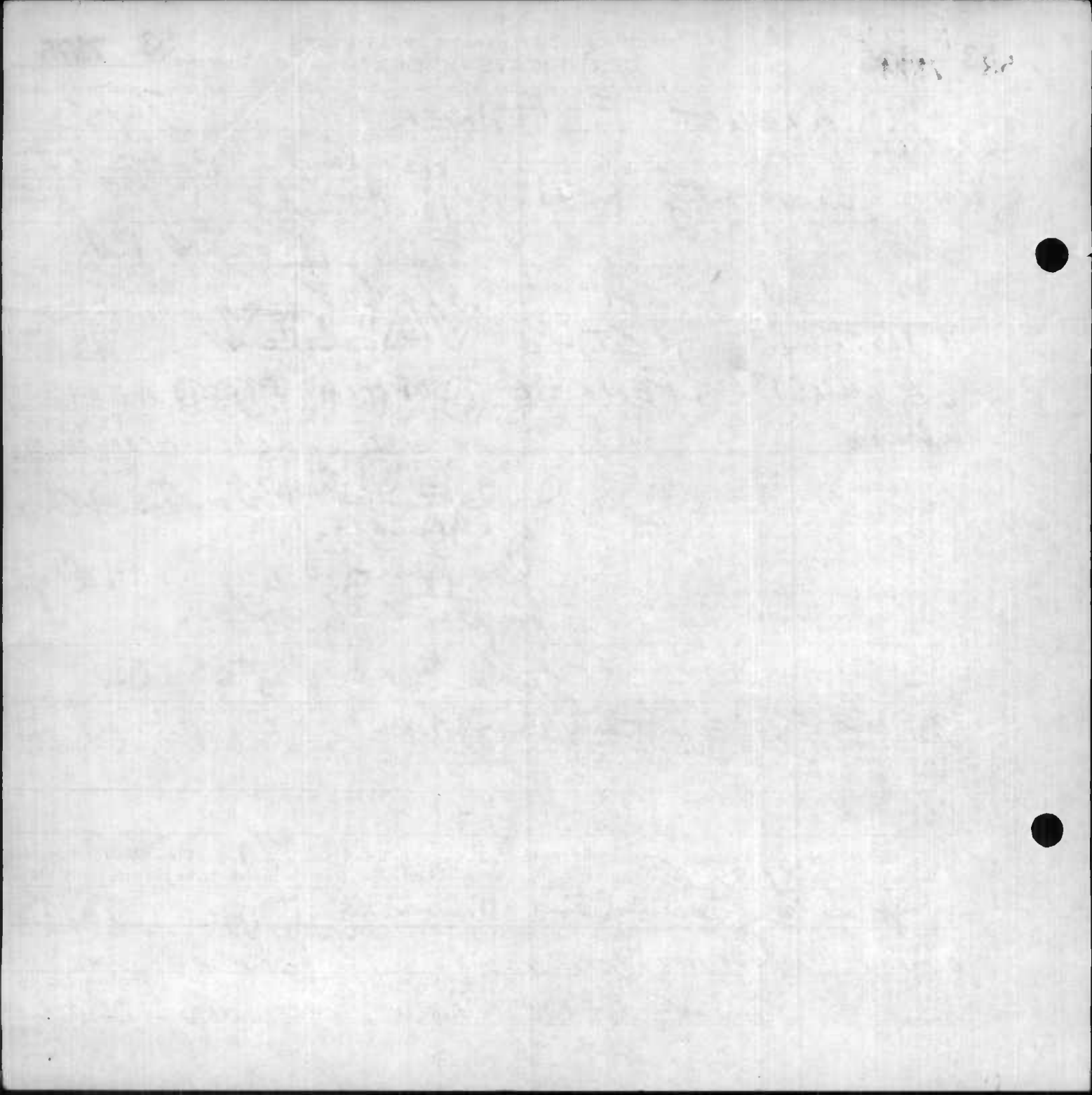
Huntington Williams

25. FUNERAL DIRECTOR

BURICK FUNERAL HOME

ADDRESS 4210

BEAIR RD





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. **53 7176**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)**JOSEPH A. SCHWARZER JR**2. DATE  
OF  
DEATH**Aug-8-1953**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

**Maryland**

B. FULL NAME OF

not in hospital or institution, give street address or location)

HOSPITAL OR  
INSTITUTION**4403 FRANK Ford**

C. CITY OR TOWN

**Baltimore**

(If outside corporate limits, write full name and give township)

D. STREET ADDRESS (If rural, give location)

**4403 FRANK Ford Ave**

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

**Male**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

**single**

8. DATE OF BIRTH

**May 29-1925**

9. AGE (in years last birthday)

**28**

If Under 1 Year

Months Days

If Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**NOT Employed**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Baltimore - Md.**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**Joseph A. Schwarzer SR**

14. MOTHER'S MAIDEN NAME

**ELEANORA E. Beckman**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

**Father**

ADDRESS

**SAME**18. **E915.0**

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) **2ND AND 3RD DEGREE BURNS APPROX. 80% OF BODY**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

**home**

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

**4413 Frankford Avenue****26/2**

21D. TIME (Month) (Day) (Year) (Hour)

**8/8/53 about 2:00 P. m.**

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

**Painting water heater when it exploded**

22. I certify that I took charge of the remains described above, held an **INSPECTION + INQUIRY** thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

**Joseph A. Jachimczyk**

M.D.

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

**8-9-53**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**8-11-1953**

24C. NAME OF CEMETERY OR CREMATORY

**Holy Redeemer**

24D. LOCATION (City, town, or county)

**BALTO**

(State)

**Md**

DATE RECEIVED BY LOCAL REGISTRAR

**AUG 10 1953**

REGISTRAR'S SIGNATURE

**Leonard J. Luck**

25. FUNERAL DIRECTOR

**Leonard J. Luck**

ADDRESS

**5305 Harford**

VS 151

**N 948.2**

2000 2000 2000

2000 2000 2000

2000 2000 2000

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **53 7177**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

**ANNA CUNNINGHAM**

2. DATE  
OF  
DEATH

**Aug 9-1953**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Maryland** B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION

**ST Joseph's**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore**

D. STREET ADDRESS (If rural, give location)

**3410 Northern Parkway**

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

**Female**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**Married**

8. DATE OF BIRTH

**Aug. 4-1910**

9. AGE (In years last birthday)

**43**

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**at home**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Baltimore Md**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**Anthony S. Madary**

14. MOTHER'S MAIDEN NAME

**Mattie Richmond**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

**Mr. Elmo Cunningham - SAME**

18. **420.1**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Acute cardiac failure**  
DUE TO **coronary artery disease, left**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) .....  
DUE TO  
(C) .....

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

**Joseph A. Jackimec**

M.D.

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED  
**8-9-53**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**Aug 12-1953**

24C. NAME OF CEMETERY OR CREMATORY

**Parkwood Cem**

24D. LOCATION (City, town, or county) (State)

**Balto Md**

DATE RECEIVED BY LOCAL REGISTRAR

**AUG 10 1953**

REGISTRAR'S SIGNATURE

**Huntington Williams, M.D.**

25. FUNERAL DIRECTOR

ADDRESS

**Leonard J. Ruck 5305 Bayford**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STAT 82

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **53 7178**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

**Richard Jones**

2. DATE  
OF  
DEATH

**Aug 9, 1953**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

**Acc Room**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

**md**

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

**JOHNS HOPKINS HOSPITAL**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**Baltimore**

O. STREET ADDRESS (If rural, give location)

**1282 Bethel St.**

C. Length of stay in Baltimore

**life**

Yrs.  
Mos.  
Days

5. SEX

**male**

6. COLOR OR RACE

**Colored**

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

**married**

8. DATE OF BIRTH

**July 10, 1899**

9. AGE (In years  
last birthday)

**54**

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

**laborer**

10B. KIND OF BUSINESS OR  
INDUSTRY

**Post Office**

11. BIRTHPLACE (State or foreign country)

**Balto, Md.**

12. CITIZEN OF  
WHAT COUNTRY?

**U.S.A.**

13. FATHER'S NAME

**Emmett Jones**

14. MOTHER'S MAIDEN NAME

**Eliza**

**?**

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

**yes**

(If yes, give war or dates of service)

**World War I**

16. SOCIAL  
SECURITY NO.

17. INFORMANT

**Viola Jones**

**1282 Bethel St. Johns Hopkins Hospital**

ADDRESS

18. **002X**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) ...

... DUE TO

**Pulmonary Tuberculosis**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) ...

... DUE TO

(C) ...

CERTIFICATION APPROVED BY

**William H. Jones**  
CHIEF OR ASST. MEDICAL EXAMINER

INTERVAL BETWEEN  
ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **8/9**, 19**53**, to **8/9**, 19**53**, that I last saw the  
deceased alive on **8/9**, 19**53**, and that death occurred at **4:25 P.M.**, from the causes and on the date stated above.

23A. SIGNATURE

**W. Gordon Walker**

M. O.

23B. ADDRESS

**JOHNS HOPKINS HOSPITAL**

23C. DATE SIGNED

**8/9/53**

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

**Burial**

24B. DATE

**8/13/53**

24C. NAME OF CEMETERY OR CREMATORY

**Balto. Natl. Cemetery**

24D. LOCATION (City, town, or county)

**Balto., Md.**

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**Thurston H. Williams, M.D., Wilson 1000 Bently**

24E. FUNERAL DIRECTOR

ADDRESS

VS 150

**To be approved by Med? Exam**  
**77090**

1955 12

1955 12

1955 12

1955 12

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1955 12

40

1955 12



K-320

3 7178

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7179

1. NAME OF DECEASED (Type or Print) Etta Gump Ketzky		2. DATE OF DEATH Aug 9, 1953	
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore, Md.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE Union Memorial Hospital 33rd. & Calvert Sts.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Maryland	
D. STREET ADDRESS (If rural, give location) 3927 Clark Lane		E. LENGTH OF STAY IN BALTIMORE life	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) divorced	8. DATE OF BIRTH 11-14-1895
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 57
13. FATHER'S NAME Abraham G. Gump		14. MOTHER'S MAIDEN NAME Jennie Hamburger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Anne K Gaynor, RFD 7 Greenspring Ave Pikesville, Md.		18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage Hypertension Arteriosclerosis generalized II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None	
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21C. TIME (Month) (Day) (Year) (Hour) INJURY		21D. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from 1953, to 9 Aug., 1953 that I last saw the deceased alive on 6 Aug., 1953, and that death occurred at 2:15 p.m., from the causes and on the date stated above.		23. ADDRESS 1207 Eutaw Place 10 Aug. '53	
24A. BURIAL, CREMATION, REMOVAL (Specify) burial		24B. DATE 8-12-53	
24C. NAME OF CEMETERY OR CREMATORY Oheb Shalom Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE RECEIVED BY LOCAL REGISTRAR AUG 10 1953		REGISTRAR'S SIGNATURE Huntington Williams, M.D.	
25. FUNERAL DIRECTOR David R. Martin		ADDRESS David R. Martin, 1902 Eutaw Place	

MEDICAL CERTIFICATION

1770

WILLIAM

CHURCH

1770

1770

1770

1770

V-300

3 7180

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7180

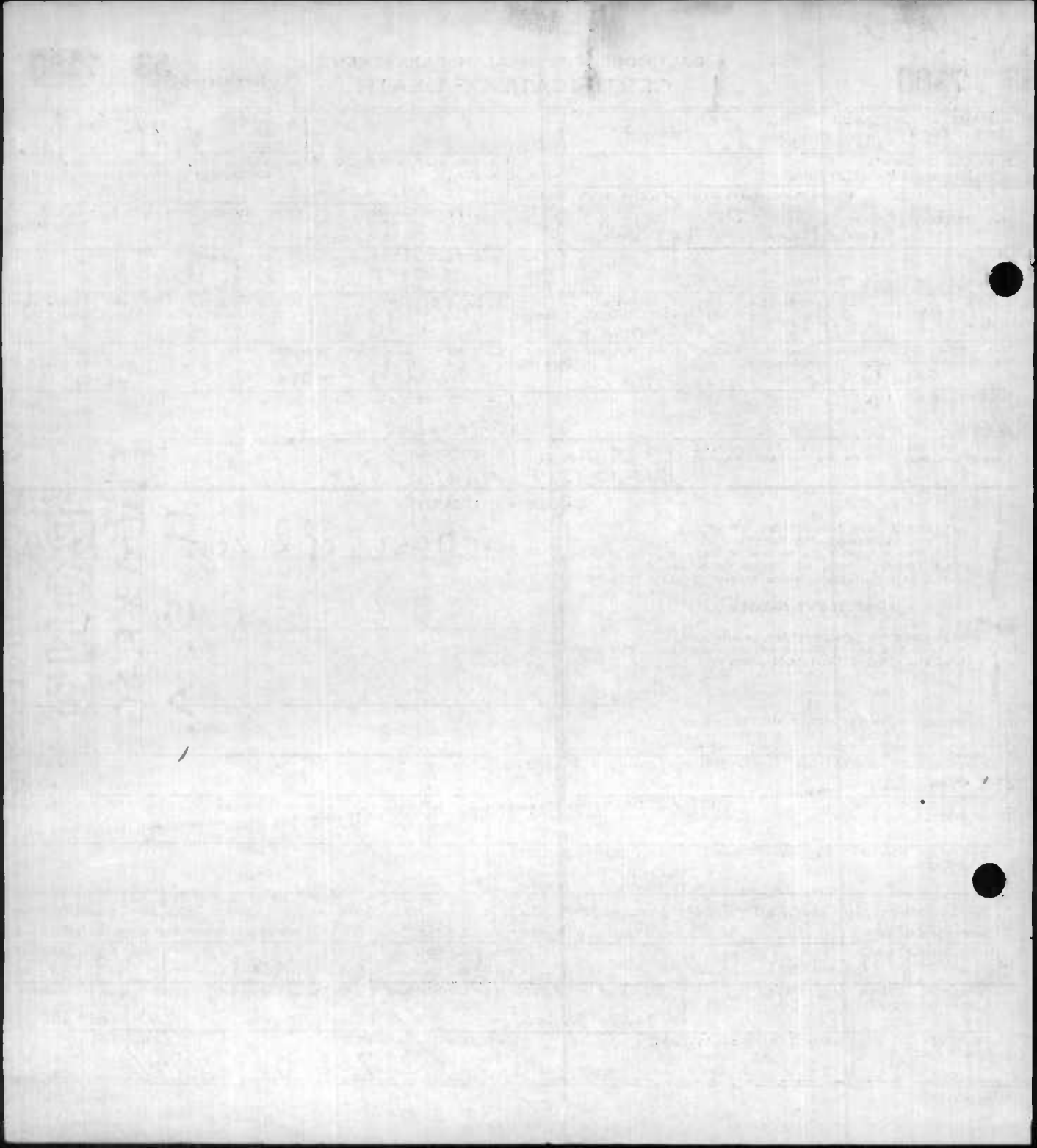
1. NAME OF DECEASED (Type or Print) <b>Arthur B. Veit, Sr.</b>		2. DATE OF DEATH <b>8/9/53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Guthrie Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore City 5351</b>	
D. STREET ADDRESS (If rural, give location) <b>5517 Selma Ave. 27</b>		5. LENGTH OF STAY IN BALTIMORE <b>LIFE</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>8/13/98</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>painter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>House PAINTER</b>	9. AGE (In years last birthday) <b>54</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY VEIT</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET BELL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-07-5219</b>	
17. INFORMANT <b>MARION VEIT</b>		ADDRESS <b>5517 Selma Ave.</b>	

18. <b>581.0</b>	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	<b>Cirrhosis of liver-</b>		<b>(?) 12 y.</b>
ANTECEDENT CAUSES	(A) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) DUE TO		

19A. DATE OF OPERATION <b>8/9/53</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>8/3</b> , 19 <b>53</b> , to <b>8/9</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>8/9</b> , 19 <b>53</b> , and that death occurred at <b>1:10 a.m.</b> , from the causes and on the date stated above.				
23A. SIGNATURE <b>J. J. Smith</b>		23B. ADDRESS <b>Guthrie Hospital</b>		23C. DATE SIGNED <b>8/9/53</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>Aug 12, 1953</b>	24C. NAME OF CEMETERY OR CREMATORY <b>LODGE PARK</b>	24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 10 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>	25. FUNERAL DIRECTOR <b>Joseph D. [unclear]</b>
VS 150		<b>56424</b>	

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **53 7181**

BIRTH NO. **7181 53-19141**

1. NAME OF DECEASED (Type or Print) <b>Baby girl porter</b>		2. DATE OF DEATH <b>8/9/53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Mercy Hospital Baltimore MD</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md</b> B. COUNTY <b>Baltimore</b>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>MJ</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore Baltimore</b>	
6. LENGTH OF STAY IN BALTIMORE		D. STREET ADDRESS (If rural, give location) <b>51 N Bell-Grove RD 420</b>	
5. SEX <b>Sim.</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>8/9/53</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <b>2 50</b>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, MD</b>	
13. FATHER'S NAME <b>Milton porter</b>		12. CITIZEN OF WHAT COUNTRY? <b>2 50</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MILTON R PORTER, 51 N. BELLE GARD RD</b>		ADDRESS	

18. <b>776X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>prematurity in bad condition</b>		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO <b>WT 1-7 1/2</b>		
(B) DUE TO <b>Length 12 inches</b>		
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Mercy</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) <b>8/9/53 10 p m.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>8-9-</b> , 19 <b>53</b> to <b>10</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>8-9</b> , 19 <b>53</b> , and that death occurred at <b>10 p m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Scheller</b>		M. D. <b>Mercy Hospital</b>		23C. DATE SIGNED <b>8-9-53</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/11/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>WESTERN</b>		24D. LOCATION (City, town, or county) (State) <b>Balti md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 10 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, MD</b>		25. FUNERAL DIRECTOR <b>Sam J. Tschner Sons Inc.</b>		ADDRESS <b>Balti md</b>	

MEDICAL CERTIFICATION

1917

22

UNITED STATES DEPARTMENT OF COMMERCE  
BUREAU OF MARITIME SERVICE  
OFFICE OF THE MARITIME COMMISSIONER

1917

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "MARITIME" and "COMMISSION" are visible.]*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

K-400

CCG-172891

53 7182

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered 53 7182

1. NAME OF DECEASED (Type or Print) <b>Henrietta Kelley</b>		2. DATE OF DEATH <b>Aug. 7, 1953</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern, Ave</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>2909 Windsor, Ave. Zone 16</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Aug. 18, 1870</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	9. AGE (In years last birthday) <b>82</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland Harford Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Abedneco</b> <b>Unknown Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Priscilla Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>B. C. H. 4940 Eastern, Ave.</b>		ADDRESS	
18. <b>422.1 and E904.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Fracture of hip.</b>		CERTIFICATION APPROVED BY <b>William J. [Signature]</b> M. D. CHIEF OR ASST. MEDICAL EXAMINER.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>7-30-53</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>2909 Windsor, Ave</b>		21F. HOW DID INJURY OCCUR? <b>Fell to the floor &amp; fractured her hip</b>	
22. I hereby certify that I attended the deceased from <b>7-30</b> , 19 <b>53</b> , to <b>8-7</b> , 19 <b>53</b> that I last saw the deceased alive on <b>8-7</b> , 19 <b>53</b> , and that death occurred at <b>3:55p</b> m., from the causes and on the date stated above.			
23A. SIGNATURE <b>H. J. [Signature]</b>		23B. ADDRESS <b>4940 Eastern, Ave. Balto, Md.</b>	
23C. DATE SIGNED <b>8-7-53</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/11/53</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 10 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	
25. FUNERAL DIRECTOR <b>Wm. J. [Signature]</b>		ADDRESS <b>Long One Balto md</b>	

To be approved by Medical Examiners

N 820.0

DATE 27

DATE 27

TIME 10:00

TIME 10:00

NAME

NAME

ADDRESS

ADDRESS

TELEPHONE

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REMARKS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7183		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 53 7183	
BIRTH NO. 53-18063		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Balmy Bay Palmer</u>		2. DATE OF DEATH <u>August 1, 1953</u>			
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>14200 Preser</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md.</u> B. COUNTY <u>Balto</u>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore Deundell</u>			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <u>1754 Brunswick Rd.</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>8-1-53</u>		9. AGE (In years last birthday) <u>15</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Maxlene Palmer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>JOHNS HOPKINS HOSPITAL</u>	
18. <u>76.5</u>		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <u>atherosclerosis</u>			
ANTECEDENT CAUSES		(B) <u>Pneumonia</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8-1</u> , 19 <u>53</u> , to <u>8-1</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>8-1</u> , 19 <u>53</u> , and that death occurred at <u>857</u> p.m., from the causes and on the date stated above.					
23A. SIGNATURE <u>Huntington Williams, M.D.</u>		23B. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>		23C. DATE SIGNED <u>20 Aug 53</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
				24D. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR <u>AUG 10 1953</u>		REGISTRAR'S SIGNATURE <u>Huntington Williams, M.D.</u>		25. FUNERAL DIRECTOR <u>7187</u>	
VS 150 <u>Hospital Disposal</u>					

1885

1885

STATE OF NEW YORK

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53

7184

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. **53 7184**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)**JOSEPH J. DUFFY**2. DATE  
OF  
DEATH**August 9, 1953**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
A. STATE B. COUNTY before admission)**Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION (not in hospital or institution, give street address or location)

**Johns Hopkins Hospital**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**Baltimore**

c. Length of stay in Baltimore

D. STREET ADDRESS (If rural, give location)

**5 N. Exeter Street**

5. SEX

**male**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**married**

8. DATE OF BIRTH

**June 14, 1912**

9. AGE (In years last birthday)

**41**

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Chemist**

10B. KIND OF BUSINESS OR INDUSTRY

**Chemical Co.**

11. BIRTHPLACE (State or foreign country)

**Wise County, Virginia**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**Edward P. Duffy**

14. MOTHER'S MAIDEN NAME

**Rachel Haney**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

**Green Funeral Home, Appalachia, Va.**18. **E812.4**

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **FRACTURE OF SKULL**  
DUE TO **CONTUSION FOEI OF BRAIN**

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **FRACTURE OF PELVIS**  
DUE TO **INTRA-ABDOMINAL INJURIES**  
(C) **MULTIPLE SKIN LACERATIONS AND ABRASIONS**

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

**street**

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

**Gough St. and Broadway****2/2**

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

**8/8/53****9:00 P.****m.**21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

**Run over by a trackless trolley**

22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

**Joseph A. Jachimczyk**

M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

**8-9-53**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Removal**

24B. DATE

**8/10/53**

24C. NAME OF CEMETERY OR CREMATORY

**Appalachia**

24D. LOCATION (City, town, or county)

**Appalachia, Virginia**

(State)

DATE RECEIVED BY LOCAL REGISTRAR

**AUG 10 1953**

REGISTRAR'S SIGNATURE

**Huntington Williams, M.D.**

25. FUNERAL DIRECTOR

**Wm. Brock, Inc., 1267 S.B. Paul**

ADDRESS

VS 151 N 804.2

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAR-172805 222 53 7185 BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 53 7185	
1. NAME OF DECEASED (Type or Print) <b>(ANTHONY) Tony Mikushouski (Mikusauskas)</b>			2. DATE OF DEATH <b>7-29-1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or hospital or INSTITUTION <b>Baltimore City Hospitals location) 4940 Eastern Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore <b>45</b> Yrs.			D. STREET ADDRESS (If rural, give location) <b>210 S. FULTON ST.</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>June 15, 1888</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>R PRESSER</b>	11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>✓</b>
13. FATHER'S NAME <b>G</b>			14. MOTHER'S MAIDEN NAME <b>G</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-03-9029</b>		17. INFORMANT ADDRESS <b>B. C. H. 4940 Eastern Ave. (records)</b>	
18. <b>490X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Right lower lobe Pneumonia</b> DUE TO			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(B)</b> <b>(C)</b>			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Hypomutrition</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7-28 1953</b> , to <b>7-29 1953</b> , that I last saw the deceased alive on <b>7-29</b> , 19 <b>53</b> , and that death occurred at <b>2:15A</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>H. A. L. B. R.</b>		23B. ADDRESS <b>4940 Eastern Ave., Balto., Md.</b>		23C. DATE SIGNED <b>7-29-53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/11/53</b>		24C. NAME OF CEMETERY, OR CREMATORY <b>HOLY REDEEMER</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO., MD.</b>		25. FUNERAL DIRECTOR <b>PHILIP W. KACHOSKAS 703 Mc HENRY ST.</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 1 0 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, Md.</b>			
VS 150					

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A-260

53 7186

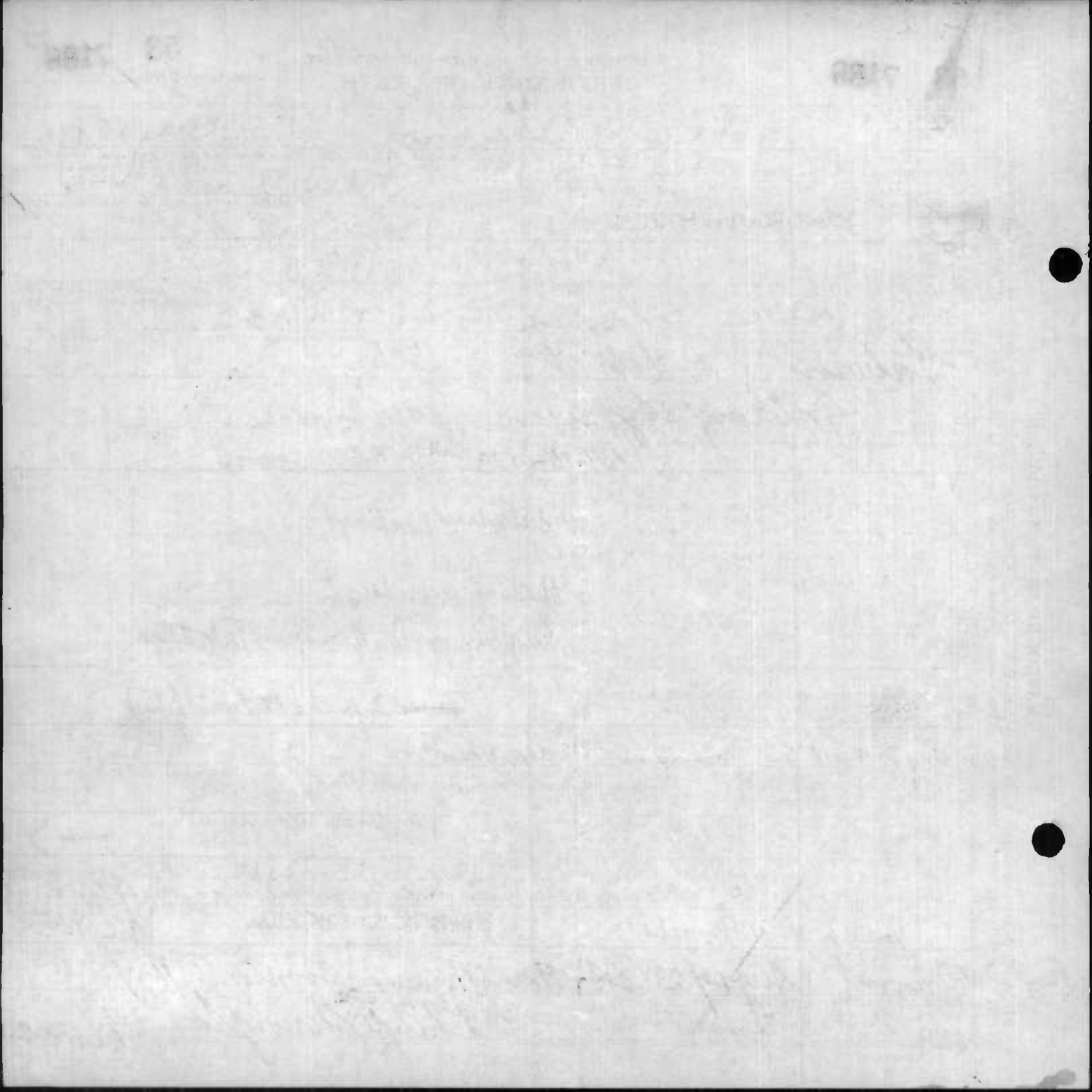
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7186

Registered No.

1. NAME OF DECEASED (Type or Print) <b>Frank Azzaro</b>		2. DATE OF DEATH <b>Aug 10, 1953</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland <b>Stal R R</b>		b. COUNTY <b>New Jersey</b>	
b. FULL NAME OF (If not in hospital or institution, give street address or location) <b>JOHNS HOPKINS HOSPITAL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Boonton N.J.</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		d. STREET ADDRESS (If rural, give location) <b>1011 Main St.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>5-21-1900</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; W. RR</b>	9. AGE (In years last birthday) <b>53</b>
11. BIRTHPLACE (State or foreign country) <b>Illay</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Anthony Azzaro</b>		14. MOTHER'S MAIDEN NAME <b>Josephine</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. INFORMANT ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>	
16. SOCIAL SECURITY NO. <b>139-14-0533</b>			
18. <b>223X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Subdural hematoma</b>		CAUSE OF DEATH (A) <b>Subdural hematoma</b> DUE TO (B) <b>Bleeding secondary to</b> DUE TO (C) <b>Surgical removal of Meningioma Tub. dellat</b>	
19. <b>223X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Subdural hematoma</b>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>None Infarcted Rt. Frontal Lobe Tip</b>			
19a. DATE OF OPERATION <b>Aug 7 - Aug 10 '53</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Meningioma 2) Subdural hematoma</b>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7/26</b> , 19 <b>53</b> to <b>8/10</b> , 19 <b>53</b> that I last saw the deceased alive on <b>8/10</b> , 19 <b>53</b> and that death occurred at <b>9:15 P.m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Joseph V. McDonald</b>		23b. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>	
23c. DATE SIGNED <b>Aug 10 '53</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>Aug 12/53</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Boonton N.J.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 11 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>	
FEDERAL DIRECTOR <b>Philip Newwig Sons</b>		ADDRESS <b>2024 Orleans St.</b>	



PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-256  
53 7187BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7187

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HENRY W. WAGNER SR.

2. DATE  
OF  
DEATH

AUGUST 8, 1953.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

MD.

B. COUNTY

2607

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

BALTIMORE CITY HOSP.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

402 S. DEAN ST.

c. Length of stay in Baltimore

LIFE Yrs.  
Mos.  
Days

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

12-3-1887

9. AGE (In years  
last birthday)

65

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

UNEMPLOYED

10B. KIND OF BUSINESS OR  
INDUSTRY

BALTO. CITY WORKER

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JACOB WAGNER

14. MOTHER'S MAIDEN NAME

LILLIAN E. MICHAEL

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WORLD WAR I

16. SOCIAL  
SECURITY NO.

218-09-8133

17. INFORMANT

FANNIE E. WAGNER

ADDRESS

SAME.

18. 420.1

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) CORONARY ARTERY DISEASE

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

HYPERTENSIVE CARDIOVASCULAR DISEASE

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an INSPECTION + INQUIRY thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

Joseph A. Jarkimeczk

23B. CHIEF MEDICAL EXAMINER.....  
M.D. ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

8-9-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

8-11-53

24C. NAME OF CEMETERY OR CREMATORY

BALTIMORE NATIONAL

24D. LOCATION (City, town, or county)

5501 FREDERICK AVE BALTO. MD.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

H. H. Williams

25. FUNERAL DIRECTOR

Charles S. Guler 901 S. CONKLING ST. BALTO. MD.

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7817 22

Heavy rain

Clouds heavy, rain falling in heavy showers.

Temperature 60° F. Wind S.W. 10 to 15 miles per hour.

Barometer 30.0 inches. Sea very rough.

At 10:00 A.M. the rain ceased and the sun appeared.

Temperature 65° F. Wind S.W. 10 to 15 miles per hour.

Barometer 30.0 inches. Sea very rough.

At 1:00 P.M. the rain began again and continued until 5:00 P.M.

Temperature 60° F. Wind S.W. 10 to 15 miles per hour.

Barometer 30.0 inches. Sea very rough.

At 8:00 P.M. the rain ceased and the sun appeared.

Temperature 65° F. Wind S.W. 10 to 15 miles per hour.



L-250

53 7188

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7188  
Registered No.

BIRTH NO. 53-18578

1. NAME OF DECEASED (Type or Print) <i>Elaine Logan</i>		2. DATE OF DEATH <i>8-10-53</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
D. STREET ADDRESS (If rural, give location) <i>1020 W. Lafayette Ave</i>		E. LENGTH OF STAY IN BALTIMORE <i>1</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>8-9-53</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>9</i> Months: <i>4</i> Days: <i>6</i>
13. FATHER'S NAME <i>Clarence Logan</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <i>Shirley Davis</i>	
17. INFORMANT ADDRESS		17. INFORMANT ADDRESS	

18. <i>762.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral Anoxia</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Apnea neonatorum</i>		(A) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(B) DUE TO			
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>8-9</i> , 1953, to <i>8-10</i> , 1953, that I last saw the deceased alive on <i>8-10</i> , 1953, and that death occurred at <i>5:10</i> Am., from the causes and on the date stated above.					
23A. SIGNATURE <i>Virginia Hunter</i>		23B. ADDRESS <i>University Hosp</i>		23C. DATE SIGNED <i>8-10-53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>8-11-53</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt Auburn Cem</i>	24D. LOCATION (City, town, or county) <i>Balt</i>	24E. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <i>H. J. Williams</i>	25. FUNERAL DIRECTOR <i>Thomas R. Hensley</i>		ADDRESS <i>20 Biddle St</i>	

MEDICAL CERTIFICATION

AUG 11 1953  
VS 150

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CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-2552		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>53 7189</b>	
MAF-172808		BIRTH NO. <b>53 7189</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Arthur Washington</b>			2. DATE OF DEATH <b>July 28, 1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>17-02</b>		
D. LENGTH OF STAY IN BALTIMORE <b>33 yrs.</b> Yrs. <b>33</b> Mos. <b>0</b> Days <b>0</b>			E. STREET ADDRESS (If rural, give location) <b>638 Hoffman St.</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Oct. 5, 1884</b>	9. AGE (In years last birthday) <b>68</b>	10. Under 1 Year Months: <b>0</b> Days: <b>0</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>George Washington</b>			14. MOTHER'S MAIDEN NAME <b>Dora Garfield</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>B. C. H.</b>			ADDRESS <b>4940 Eastern Ave. (records)</b>		
18. <b>331X</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Vascular Accident</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>7-28</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7-28</b> , 19 <b>53</b> to <b>7-28</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>7-28</b> , 19 <b>53</b> and that death occurred at <b>9:10P</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>Dr. John R. ...</b>		23B. ADDRESS <b>4940 Eastern Ave., Balto., Md.</b>		23C. DATE SIGNED <b>7-28-1953</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
24D. DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 11 1953</b>		24E. REGISTRAR'S SIGNATURE <b>H. ...</b>		24F. FUNERAL DIRECTOR <b>7 ...</b>	
24G. ADDRESS		24H. ADDRESS			

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**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Registered No. 53 7190

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Anthony Andrews		8-2-1953	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-12	
5. Length of stay in Baltimore 4yrs.		D. STREET ADDRESS (If rural, give location) Baltimore City Hospitals 4940 Eastern Ave., Baltimore, 24, Md.	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Dec. 28-1892
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 60
13. FATHER'S NAME Anthony Andrews		11. BIRTHPLACE (State or foreign country) Lithuania	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? 14. MOTHER'S MAIDEN NAME Annie ?	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS 4940 Eastern Ave., Records: Baltimore City Hospitals	

1B.	526 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH (A) <u>Emphysema</u> DUE TO	INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) <u>Bronchiectasis</u> DUE TO (C)	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from 2-1-1948, to 8-2-1953 that I last saw the deceased alive on 2-1-1948, and that death occurred at 8-25 AM; from the causes and on the date stated above.		21F. HOW DID INJURY OCCUR?	
23A. SIGNATURE <u>H. J. [Signature]</u>		23B. ADDRESS <u>4940 Eastern Ave., Baltimore, Md.</u> 23C. DATE SIGNED <u>8-2-1953</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR AUG 11 1953		REGISTRAR'S SIGNATURE <u>Huntington Williams, MD</u> 25. FUNERAL DIRECTOR <u>7 Huntington Williams, MD</u> ADDRESS	

VS 150

See query reply in Document file.



5-300  
53 7191BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHX 53 7191  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Mary Scott</i>		2. DATE OF DEATH <i>Aug 9 - 1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, or institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Little Sisters of the Poor</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balt.</i>	
Length of stay in Baltimore <i>4 years</i>		D. STREET ADDRESS (If rural, give location) <i>3803 Lawrentown Rd.</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE MARRIED, WIDOWED, DIVORCED (Specify) <i>DIVORCED</i>	8. DATE OF BIRTH <i>March 4 1869</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) Months Days <i>84</i>
13. FATHER'S NAME <i>John Gallagher</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <i>Caroline Baker</i>	
17. INFORMANT <i>Little Sisters of the Poor</i>		ADDRESS	

18. <i>331X</i>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) <i>Cerebral Hemorrhage</i> DUE TO	<i>2 day</i>
ANTECEDENT CAUSES	(B) <i>Arterio Sclerosis</i> DUE TO	<i>1 yr</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>July 4 -</i> , 19 <i>53</i> to <i>Aug 9 -</i> , 19 <i>53</i> that I last saw the deceased alive on <i>Aug 8 -</i> , 19 <i>53</i> , and that death occurred at <i>m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>P. J. Hall</i>		23B. ADDRESS <i>1631 E. North Ave</i>		23C. DATE SIGNED <i>Aug 10 1953</i>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Aug 13 1953</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Cathedral</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 11 1953</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>	25. FUNERAL DIRECTOR <i>Rita W. Wedel</i>
		ADDRESS <i>2906 Biddle St</i>	

1000

1000

RECEIVED BY THE DEPARTMENT OF HEALTH

1000

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of jury		12. Signature of witnesses	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery		16. Signature of burial place	
17. Signature of interment		18. Signature of cremation		19. Signature of disposition		20. Signature of final disposition	
21. Signature of final disposition		22. Signature of final disposition		23. Signature of final disposition		24. Signature of final disposition	
25. Signature of final disposition		26. Signature of final disposition		27. Signature of final disposition		28. Signature of final disposition	
29. Signature of final disposition		30. Signature of final disposition		31. Signature of final disposition		32. Signature of final disposition	
33. Signature of final disposition		34. Signature of final disposition		35. Signature of final disposition		36. Signature of final disposition	
37. Signature of final disposition		38. Signature of final disposition		39. Signature of final disposition		40. Signature of final disposition	
41. Signature of final disposition		42. Signature of final disposition		43. Signature of final disposition		44. Signature of final disposition	
45. Signature of final disposition		46. Signature of final disposition		47. Signature of final disposition		48. Signature of final disposition	
49. Signature of final disposition		50. Signature of final disposition		51. Signature of final disposition		52. Signature of final disposition	
53. Signature of final disposition		54. Signature of final disposition		55. Signature of final disposition		56. Signature of final disposition	
57. Signature of final disposition		58. Signature of final disposition		59. Signature of final disposition		60. Signature of final disposition	
61. Signature of final disposition		62. Signature of final disposition		63. Signature of final disposition		64. Signature of final disposition	
65. Signature of final disposition		66. Signature of final disposition		67. Signature of final disposition		68. Signature of final disposition	
69. Signature of final disposition		70. Signature of final disposition		71. Signature of final disposition		72. Signature of final disposition	
73. Signature of final disposition		74. Signature of final disposition		75. Signature of final disposition		76. Signature of final disposition	
77. Signature of final disposition		78. Signature of final disposition		79. Signature of final disposition		80. Signature of final disposition	
81. Signature of final disposition		82. Signature of final disposition		83. Signature of final disposition		84. Signature of final disposition	
85. Signature of final disposition		86. Signature of final disposition		87. Signature of final disposition		88. Signature of final disposition	
89. Signature of final disposition		90. Signature of final disposition		91. Signature of final disposition		92. Signature of final disposition	
93. Signature of final disposition		94. Signature of final disposition		95. Signature of final disposition		96. Signature of final disposition	
97. Signature of final disposition		98. Signature of final disposition		99. Signature of final disposition		100. Signature of final disposition	

53 7192

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7192  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Josephine Jackson

2. DATE  
OF  
DEATH

Aug 8 - 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Lincoln Hospital

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(If not in hospital or institution, give street address or location)

Lincoln Convalescence Hosp

4. USUAL RESIDENCE (Where deceased lived in Institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

320 Shennadoles Ave Annapolis  
(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore

35

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Noel

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Ernest Noel 511 Bloom St

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Arterio sclerotic Hardis  
DUE TO Vascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Generalized Arterio  
DUE TO sclerosisII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Amputation of both legs

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from 7-31, 1953 to 8-8, 1953 that I last saw the  
deceased alive on 8/6, 1953 and that death occurred at 5:15 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

E. Wallis Shennigton M. D.

2301 Harlem Ave

8/11/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 11 1953

Ernest Noel

V. Brooke Faggold 14637 Cary St

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

53 7193  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CATHERINE V. FRENCH

2. DATE  
OF  
DEATH

8/7/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland 911 Light Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Md.

B. COUNTY

before admission)

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

24-03

D. STREET ADDRESS (If rural, give location)

911 Light Street

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

10/8/68

9. AGE (In years  
last birthday)

84

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housework

10B. KIND OF BUSINESS OR  
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

James McKenney

14. MOTHER'S MAIDEN NAME

Mariah Fardwell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Family - Same

18. 420.0

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

Hypertensive - Arteriosclerotic  
Heart disease

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

15 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

Generalized Arteriosclerosis

Senility

15 yrs.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 4, 1953, to Aug. 7, 1953, that I last saw the  
deceased alive on Aug. 5, 1953, and that death occurred at 11:00 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Ben Blackman

M. D.

23B. ADDRESS

1228 S. Charles

23C. DATE SIGNED

8/10/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

B

24B. DATE

8/11/53

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

James L. McCally - 130 East Fort Avenue

ADDRESS

AUG 11 1953

VS 150

DATE 02

DATE 02

WATLEY  
CO. 1000  
BOLD  
10000000



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

L-200

53 7194

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7194

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Amelia Laws

2. DATE  
OF  
DEATH

Aug. 8, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, or institution; residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

1426 Madison Ave.

C. CITY OR TOWN

Baltimore 14-01

D. STREET ADDRESS (If rural, give location)

1426 Madison Ave.

C. Length of stay in Baltimore

39 yrs.

5. SEX

Female Colored

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Mar. 4, 1860

9. AGE (in years last birthday)

93

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Alabama

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

No

17. INFORMANT

Wm. Gladys Taylor Smith

Upper Marlboro, Md.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ...

Coronary thrombosis

Aug. 8, 1953

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ...

Hypertensive Cardio Vascular Disease

Unknown

(C) ...

Arterio Sclerosis and Renal

Long standing

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Chronic Interstitial Nephritis

19A. DATE OF OPERATION

No

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

None

19. OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II

PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

No

21B. PLACE OF INJURY (e.g., to or about home, farm, factory, street, office bldg., etc.)

No

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

No

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

No

22. I hereby certify that I attended the deceased from July 12, 1953, to Aug 8, 1953, that I last saw the deceased alive on Aug 8, 1953, and that death occurred at 1:30 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Ralph J. Young

23B. ADDRESS

1532 E. Monument St

23C. DATE SIGNED

8/8/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial Aug. 11, 1953

24B. DATE

Aug. 11, 1953

24C. NAME OF CEMETERY OR CREMATORY

Whitely Mem. Pk.

24D. LOCATION (City, town, or county)

Baltimore Co. Md.

State

DATE RECEIVED BY LOCAL REGISTRAR

Aug. 11, 1953

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

1631 David Hill Ave.

ADDRESS

Home

1917 22

1917 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-320

53 7195

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7195

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>(Rev) Sarah J. Matthews</i>		2. DATE OF DEATH <i>Aug. 9, 1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>1600 Spray Ct.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 15-01</i>	
D. STREET ADDRESS (If rural, give location) <i>1600 Spray Ct.</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Colored</i>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>		8. DATE OF BIRTH <i>June 9, 1888</i> 63	
9. AGE in years last birthday		10. UNDER 1 Year Months: Days	
11. UNDER 24 Hours Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Minister</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Church</i>	
11. BIRTHPLACE (State or foreign country) <i>Rembridge, Va</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Solomon Bagley</i>		14. MOTHER'S MAIDEN NAME <i>Hattie Jones</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>110-0101010101</i>	
17. INFORMANT <i>Mrs. Eric Samuels</i>		ADDRESS <i>217 N. Payson St.</i>	

18. <i>442 X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO		CAUSE OF DEATH <i>Coronary vascular renal disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		(B)			
(C)					

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from *Jan 23*, 1953 to *Aug 9*, 1953 that I last saw the deceased alive on *Aug 8*, 1953, and that death occurred at *6 a. m.*, from the causes and on the date stated above.

23A. SIGNATURE <i>John E. S. Camper</i>		23B. ADDRESS <i>1639 N. Carey St</i>		23C. DATE SIGNED <i>Aug 10, 1953</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Aug 13, 1953</i>		24C. NAME OF CEMETERY OR CREMATORY <i>W. Auburn</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		24E. FUNERAL DIRECTOR <i>W. H. Hall</i>		24F. ADDRESS <i>1631 S. Mid Hill Ave</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 11 1953</i>		REGISTRAR'S SIGNATURE <i>H. E. Williams</i>		25. FUNERAL DIRECTOR'S ADDRESS <i>1631 S. Mid Hill Ave</i>	

VS 150

0098W

2007

2007

2007

2007

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-325  
53 7186BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7186  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

James W. Hudson

2. DATE  
OF  
DEATH

8/9/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

3515 Roland Ave

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto. 13-06

D. STREET ADDRESS (If rural, give location)

3515 Roland Ave.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

11/7/1887

9. AGE (In years  
last birthday)

65

H Under 1 Year  
Months: DaysH Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Clerk Food Market Ice Cream Co.

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Chas. W. Hudson

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

217-09-6013

17. INFORMANT

Janis R. Hudson 3515 Roland Ave.

ADDRESS

18. 422.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) .....  
DUE TOARTERIOSCLEROTIC CARDIOVAS-  
CULAR DISEASEINTERVAL BETWEEN  
ONSET AND DEATH

30 YEARS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) .....  
DUE TO  
(C) .....

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

NONE

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH. ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 9, 1953, to Aug 9, 1953, that I last saw the  
deceased alive on Aug 9, 1953, and that death occurred at 7:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Joseph H. Bird

23B. ADDRESS

1532 Havenwood Rd

23C. DATE SIGNED

Aug 10 1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8/12/53

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn

24D. LOCATION (City, town, or county)

Woodlawn Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

AUG 11 1953

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

W. A. Sprad. 217 St. Paul St.

ADDRESS

VS 150

39041

2017

20

2017

20



15-452  
53 7197BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7197  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BARBARA

KLUNK

2. DATE  
OF  
DEATH

August 9, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)A. STATE  
Maryland

B. COUNTY

B. FULL NAME OF (not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

Union Memorial Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5714 W. Greenspring Avenue

c. Length of stay in Baltimore

16

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

July 19

9. AGE (In years  
last birthday)

20

If Under 1 Year

Months Days

If Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRYScientific Research  
SILVERWAKE MFG.

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Albert J. Klunk

14. MOTHER'S MAIDEN NAME

Hilda Hyde

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown)  
NO

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

213-30-4746

17. INFORMANT

ADDRESS

Albert J. Klunk 5520 Mattfeldt Ave.

18.

E 815.4

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Skull Fracture

XXXX

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Multiple Contusions and Abrasions

XXXX

(C) Amputation of Left Leg

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

4700 block Falls Road

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

8-9-53 9:00 P.

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE ☒21F. HOW DID INJURY OCCUR?  
Passenger on motorcycle that went out of

inspection &amp; inquiry

22. I certify that I took charge of the remains described above, held an  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion, resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
M.D. MEDICAL INVESTIGATOR ☐23C. DATE SIGNED  
8-10-5324A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 12-1953

24C. NAME OF CEMETERY OR CREMATORY

Conewago Cemetery

24D. LOCATION (City, town, or county)

Hanover

(State)

Penna

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 151

N 803.2

0993 Z

Thank H. Seitz 814 W 36th St.

1917

1917



53 7198

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7198  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print) *Mrs Blanche D. Robinson*2. DATE OF DEATH *August 9 1953*3. PLACE OF DEATH:  
A. Baltimore City, MarylandB. FULL NAME OF HOSPITAL OR INSTITUTION *Hood Convalescent Home*

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE *md*

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) *Baltimore 20-02*D. STREET ADDRESS (If rural, give location) *2747 Edmondson Ave*C. Length of stay in Baltimore *12*5. SEX *Female* 6. COLOR OR RACE *White* 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) *Widowed* 8. DATE OF BIRTH *Aug 20, 1871* 9. AGE (In years last birthday) *81* 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.10A. USUAL OCCUPATION (Give kind of work done during most of working life, if retired) *House Wife*10B. KIND OF BUSINESS OR INDUSTRY *At Home*13. FATHER'S NAME *Boyle*11. BIRTHPLACE (State or foreign country) *Youngstown Ohio*

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME *Unknown*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS *Lucille M. Walters 505 Edgewood St*18. *231X*

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

*Cerebrovascular Accident*

INTERVAL BETWEEN ONSET AND DEATH

*18 hrs.*

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

*Arteriosclerosis*

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION *0*

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *August 8, 1953*, to *Aug 9, 1953*, that I last saw the deceased alive on *Aug 8, 1953* and that death occurred at *10:10 a.m.*, from the causes and on the date stated above.23A. SIGNATURE *Leslie C. Hall*23B. ADDRESS *1039 St. Paul St*23C. DATE SIGNED *Aug 9 1953*24A. BURIAL, CREMATION, REMOVAL (Specify) *Burial*24B. DATE *Aug 12 1953*24C. NAME OF CEMETERY OR CREMATORY *Western*24D. LOCATION (City, town, or county) (State) *Baltimore Md*DATE RECEIVED BY LOCAL REGISTRAR *AUG 11 1953*REGISTRAR'S SIGNATURE *Thurston William*

25. FUNERAL DIRECTOR

ADDRESS *John F. Teyfel 5311 Edmondson Ave*

2010

10

10/10/10 10:10:10

10/10/10 10:10:10

2010 10

(2) B-656

53 7199

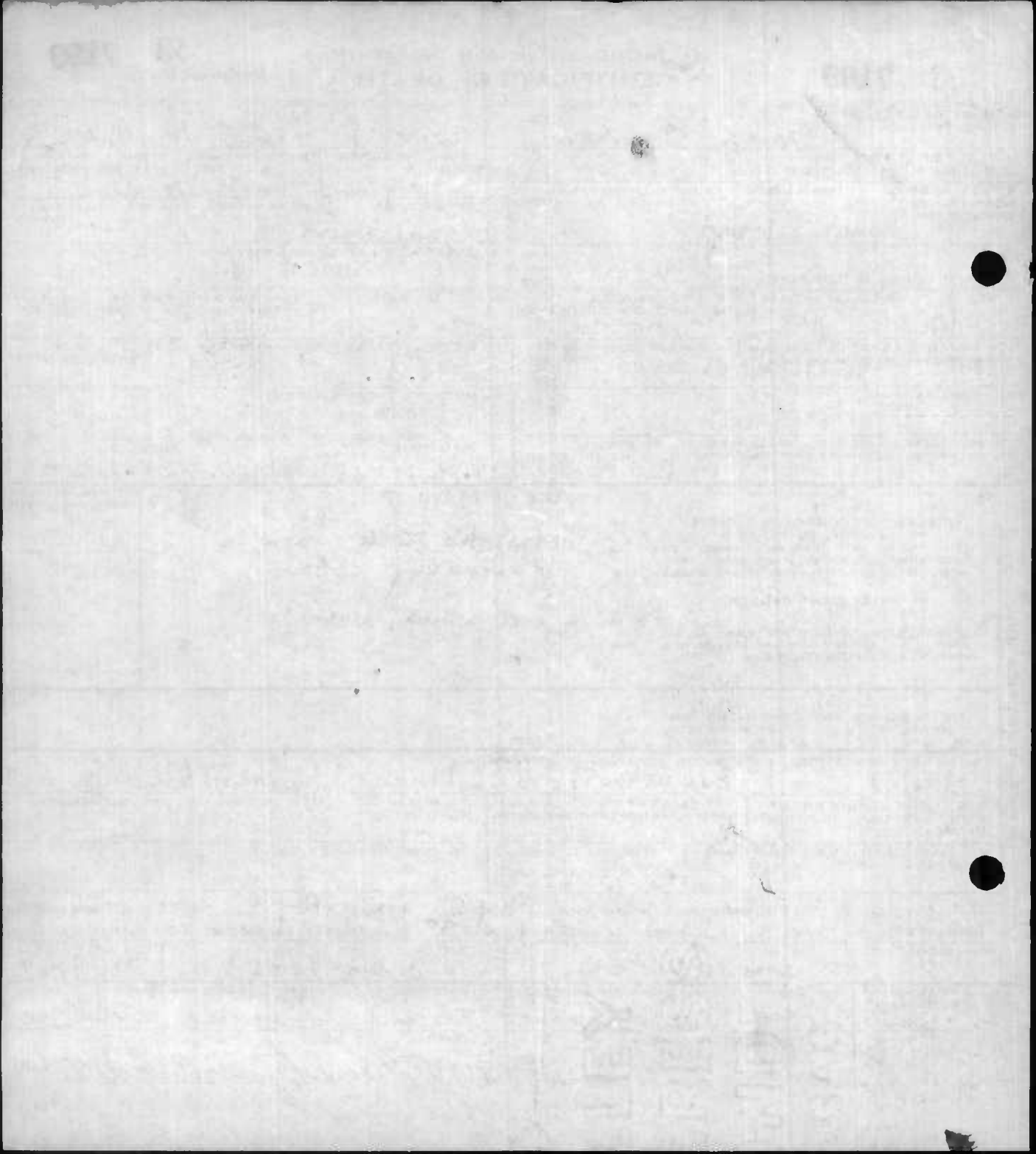
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7199  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Max Bernhard (Bernhard)</b>		2. DATE OF DEATH <b>Aug 9, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hosp.</b>		6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 19-04</b>			
7. Length of stay in Baltimore <b>Life</b>		8. STREET ADDRESS (If rural, give location) <b>423 S. Vincent St</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>		9. AGE (in years last birthday) <b>53</b>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician helper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Clarence Tins Co</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
13. FATHER'S NAME <b>Bernhard</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. <b>215 03 3429</b>		17. INFORMANT ADDRESS <b>Mrs. Gertrude Bernhard, 423 S. Vincent</b>	
18. <b>153X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>metastases from ca of descending colon.</b>		CAUSE OF DEATH <b>St</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>anemia, inanition</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>Aug. 7</b>		19B. MAJOR FINDINGS OF OPERATION <b>Evacuation of clots from bladder; fulguration of bladder</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Aug 4, 1953</b> to <b>Aug 9, 1953</b> that I last saw the deceased alive on <b>Aug. 9, 1953</b> and that death occurred at <b>3:00 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Guinea Helle</b>		23B. ADDRESS <b>Sinai Hosp.</b>		23C. DATE SIGNED <b>Aug 9, 1953</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 12, 1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	
24D. LOCATION (City, town, or county) <b>Ba. Md.</b>		25. FUNERAL DIRECTOR ADDRESS <b>Huntington Williams Harry H. Quitzke, 4101 Edmondson Ave.</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 11 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>		VS 150	

MEDICAL CERTIFICATION

51524

Ave.





53 7200

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7200  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Flora Suter

2. DATE  
OF  
DEATH

Aug. 9/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION General German Reed 22 S. Athol Ave4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)  
A. STATE Md.  
B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)  
Baltimore 28-04

D. STREET ADDRESS (If rural, give location)

22 S. Athol Ave.

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 9, 1880

9. AGE (In years  
last birthday)

75

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR  
INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Louis Becker

14. MOTHER'S MAIDEN NAME

Christiana Rasch

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Sr. Fredericka, 22 S. Athol Ave

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Cardiac - Respiratory failure  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Myocardial infarction  
DUE TO

(C) Arterio-sclerosis, severe

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 10, 1953 to 9 Aug, 1953 that I last saw the  
deceased alive on 5 Aug, 1953 and that death occurred at 4:20 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 11/53

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 11 1953

Huntington W. P. ...

Harry H. Kutzke

4101 Edmondson Ave



L-520

53 7201

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7201  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

THOMAS A. LYNCH

2. DATE  
OF  
DEATH

8-9-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Bon Secours Hospital

C. Length of stay in Baltimore

55 Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

MARYLAND

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

153 S. MONASTERY AVE

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

STEAMFITTER

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

JOHN LYNCH

14. MOTHER'S MAIDEN NAME

MARY McHUGH

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

UNKNOWN No

16. SOCIAL  
SECURITY NO.

211-03-3750

17. INFORMANT

Wife

ADDRESS

153 S. MONASTERY AVE

18. 420.1 I CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) MYOCARDIAL INFARCTION

1 HOUR

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Hypertensive Cardiovascular

1 YEAR

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1952, to Aug 9, 1953, that I last saw the  
deceased alive on Aug 9, 1953, and that death occurred at 8:30 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Edward L. J. Krieg M.D.

23B. ADDRESS

4508 Edmondson Village

23C. DATE SIGNED

9 Aug 53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

Aug 13 1953

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Baltimore Maryland

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

J. Truman Schuch

ADDRESS

3512 Frederick Ave.

VS 150

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Frederick Ave.

MEDICAL CERTIFICATION

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-650

7202

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7202

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Mary Brown</b>		2. DATE OF DEATH <b>August 9, 1953</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1117 Carson Ct.</b>		C. CITY OR TOWN <b>Balto.</b>	
c. Length of stay in Baltimore <b>?</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>1117 Carson Ct.</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>V</b>	8. DATE OF BIRTH <b>1880</b>
10A. USUAL OCCUPATION (Give kind of work done during most of year, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>OA Pensioner</b>	9. AGE (In years last birthday) <b>73</b>
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Washington</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>John Brown</b>		ADDRESS <b>1117 Carson Ct.</b>	
18. <b>420.1</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>8/13/53</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>8-4</b> , 19 <b>53</b> , to <b>8/9</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>8/7</b> , 19 <b>53</b> , and that death occurred at <b>11:34</b> a.m., from the causes and on the date stated above.			
23A. SIGNATURE <b>Joseph R. Kelson</b>		23B. ADDRESS <b>1707 Redwood Ave</b>	
23C. DATE SIGNED <b>8/10/53</b>		23D. DATE SIGNED	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/13/53</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 11 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, Md.</b>	
VS 150		25. FUNERAL DIRECTOR <b>Geo. G. Kelson</b>	
		ADDRESS <b>1303 Presstman St.</b>	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# H-620 CERTIFICATE CORRECTED 8-13-53

## BALTIMORE CITY HEALTH DEPARTMENT

### CERTIFICATE OF DEATH

Registered No. **53 7203**

BIRTH NO. <b>53 7203</b>		1. NAME OF DECEASED (Type or Print) <b>EDWARD C. HORSEY</b>		2. DATE OF DEATH <b>August 10, 1953</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Calvert</b>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Sherwood</b>			
c. Length of stay in Baltimore <b>12 hrs.</b>		D. STREET ADDRESS (If rural, give location)			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Feb. 19, 1929</b>	9. AGE (In years last birthday) <b>23 24</b>	If Under 1 Year Months Days If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Cannery</b>		11. BIRTHPLACE (State or foreign country) <b>McDaniel, Talbot Co., Md.</b>	
13. FATHER'S NAME <b>Edward Horsey Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Hohney</b>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-24-42542</b>		17. INFORMANT ADDRESS <input checked="" type="checkbox"/> <b>Katherine Hohney, Sherwood, Md.</b>	
18. <b>401.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTecedent CAUSES</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) <b>Fibrinous pericarditis</b> <del>Cardiac hypertrophy and dilatation</del> (B) <b>Congenital hypoplasia of right kidney</b> <del>due to</del> (C) <b>Chronic glomerulonephritis</b>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Uremia and Aplastic anemia</b>			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <b>autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>Joseph A. J. [Signature]</b>		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <b>Aug. 11, 1953</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>8/16/53</b>		24B. DATE <b>8/16/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Sherwood Col. Sherwood Talbot Md</b>	
24D. LOCATION (City, town, or county) (State) <b>Sherwood Talbot Md</b>		25. FUNERAL DIRECTOR <b>J. [Signature]</b>		ADDRESS <b>Belghman Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 11 1953</b>		REGISTRAR'S SIGNATURE <b>William [Signature]</b>			

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CERTIFICATE OF DEATH

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B-652

3 7204

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7204

1. NAME OF DECEASED (Type or Print) <i>Ediza Barnes</i>		2. DATE OF DEATH <i>8-10-53</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>2101 W. Cold Spring</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Balto</i>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore-Wal-Ba Nursing Home</i>		6. STREET ADDRESS (If rural, give location) <i>1420 Waltr Meyer Ct</i>	
7. Length of stay in Baltimore <i>50</i> Yrs. Mos. Days		8. DATE OF BIRTH <i>Mar 10, 1900</i>	
9. SEX <i>F</i>		9. AGE (in years last birthday) <i>53</i>	
10. COLOR OR RACE <i>C</i>		11. BIRTHPLACE (State or foreign country) <i>St. Mary's Co. Md</i>	
12. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>W</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Mr H Barnes</i>		14. MOTHER'S MAIDEN NAME <i>Minnie?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Fluence Stone-2127 New Bun</i>	

18. <i>442X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cardio Vascular Renal Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>?</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>Aug 8, 53</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Aug 8, 53</i> to <i>Aug 10, 53</i> , that I last saw the deceased alive on <i>Aug 8, 53</i> , and that death occurred at <i>10 a</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>H. J. Johnson</i>		23B. ADDRESS <i>403 Med Arts Bldg</i>		23C. DATE SIGNED <i>8-10-53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>B</i>		24B. DATE <i>8-13-53</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn</i>	
24D. LOCATION (City, town, or county) <i>Balto. Md</i>		24E. FUNERAL DIRECTOR <i>William W. Sullivan Jr</i>		24F. ADDRESS <i>Huntington</i>	

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OFFICE OF THE  
ATTORNEY GENERAL

AUG 84



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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7205

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7205  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		Alice J. Wood		Aug. 9-1953	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
B. FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE			
703 W. Lafayette Ave		Md			
C. Length of stay in Baltimore		C. CITY OR TOWN (If outside corporate limits, write R.U.R.A. and give township)			
Yrs. Mos. Days		Baltimore			
5. SEX		6. COLOR OR RACE		D. STREET ADDRESS (If rural, give location)	
F		C		703 W. Lafayette Ave	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
m		Oct. 19-1903		49	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Chesterfield Co. Va.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Isaac Johnson		Rebecca Miller			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				James Wood-703 W. Laf. Ave	
18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
(A) DUE TO		Hypertensive Cardiovascular Disease			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 7-17-1952 to 8-9-1953 that I last saw the deceased alive on 8-9-1953, and that death occurred at 7:00 A.M., from the causes and on the date stated above.					
23A. SIGNATURE		23B. ADDRESS		23C. DATE SIGNED	
Thomas J. Whiddon, M.D.		703 W. Lafayette Ave		8-10-53	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
13		4-13-53		First Baptist Cem	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR ADDRESS	
AUG 11 1953		Huntington Williams, M.D.		Samuel W. Sullivan, Jr.	
VS 150		1011 N. Arlwayton Ave			

2015

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Office of the Mayor

City of New York

Department of the City Clerk

City Hall

New York, N.Y.

January 1, 2015

Dear Sir:

I am pleased to inform you that

your application for the position of

City Clerk has been received and

is being reviewed.

Sincerely,

Mayor

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-650 53 7206				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		53 7206 Registered No.	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>MILTON H. BROWN</b>		2. DATE OF DEATH <b>August 9, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph's Hospital</b>				D. STREET ADDRESS (If rural, give location) <b>4611 Kavon Avenue</b>		26-07	
c. Length of stay in Baltimore				5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>				8. DATE OF BIRTH <b>July 21, 1912</b>		9. AGE (In years last birthday) <b>41</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist, Bethlehem Steel Co</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>William H. Brown</b>				14. MOTHER'S MAIDEN NAME <b>Elsie May</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Irene D. Brown, 4611 Kavon Ave.</b>	
18. <b>E974X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Asphyxiation due to hanging</b> <del>XXXX</del>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) ..... (C) .....							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION				19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>4611 Kavon Avenue</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>8-9-53 2:30 P.</b>				21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>hanged self by electric cord</b>	
22. I certify that I took charge of the remains described above, held an <b>inspection &amp; inquiry</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , <b>suicide</b> <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
23A. SIGNATURE <i>William H. Brown</i>				23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>8-10-53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 12, 1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Hampton, Maryland</b>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>		25. FUNERAL DIRECTOR <b>Leonard J. Ruck</b>		ADDRESS <b>5305 Harford Road.</b>	
VS 151 N991X				5443A			

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

*Med. Exam case - Released to Hosp. To be approved*

**BALTIMORE CITY HEALTH DEPARTMENT**  
**CERTIFICATE OF DEATH**

**53 7207** Registered No. **53 7207**

**BIRTH NO.**

**1. NAME OF DECEASED (Type or Print)** *MARGARIT.TA (MARGORITA) Faby*

**2. DATE OF DEATH** *AUG 11 1953*

**3. PLACE OF DEATH:**  
**A. Baltimore City, Maryland** *Emergency*  
**B. FULL NAME OF HOSPITAL OR INSTITUTION** *JOHNS HOPKINS HOSPITAL*  
**C. Length of stay in Baltimore** Yrs. Mos. Days

**4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)**  
**A. STATE** *Md.* **B. COUNTY** *Baltimore*  
**C. CITY OR TOWN** *Baltimore*  
**D. STREET ADDRESS (If rural, give location)** *4113 Joppa Rd. 5355*

**5. SEX** *female* **6. COLOR OR RACE** *white* **7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)** *Married*

**8. DATE OF BIRTH** *Aug 18-1905* **9. AGE (In years last birthday)** *47* **If Under 1 Year** Months: Days: **If Under 24 Hours** Hours: Min.

**10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)** *At Home* **10B. KIND OF BUSINESS OR INDUSTRY**

**11. BIRTHPLACE (State or foreign country)** *BALTO Md* **12. CITIZEN OF WHAT COUNTRY?** *USA*

**13. FATHER'S NAME** *E. Stresaweski* **14. MOTHER'S MAIDEN NAME** *A. Hottin*

**15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)** *(If yes, give war or dates of service)* **16. SOCIAL SECURITY NO.** **17. INFORMANT** *JOHNS HOPKINS HOSPITAL* **ADDRESS**

**18. 443X** **CAUSE OF DEATH**  
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) *Cerebrovascular accident*  
**ANTECEDENT CAUSES** *Hypertensive arteriosclerotic cardiac-vascular disease*  
**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.**  
**OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.** *II*  
**CERTIFICATION APPROVED BY** *Joseph P. Johnson M.D.*  
**CHIEF OR ASST. MEDICAL EXAMINER.**

**19A. DATE OF OPERATION** **19B. CONDITION FOR WHICH OPERATION WAS PERFORMED** **IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II** **20. AUTOPSY?** YES ☐ NO ☒

**21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)** **21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)** **21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?**

**21D. TIME (Month) (Day) (Year) (Hour) OF INJURY** **21E. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐ **21F. HOW DID INJURY OCCUR?**

**22. I hereby certify that I attended the deceased from** *8-11-1953* **to** *8-11-1953* **that I last saw the deceased alive on** *8-11-1953* **and that death occurred at** *12067* **from the causes and on the date stated above.**

**23A. SIGNATURE** *John L. Hedrum* **23B. ADDRESS** *JOHNS HOPKINS HOSPITAL* **23C. DATE SIGNED** *8-11-53*

**24A. BURIAL, CREMATION, REMOVAL (Specify)** *Burial* **24B. DATE** *8/14/1953* **24C. NAME OF CEMETERY OR CREMATORY** *Mareland Park* **24D. LOCATION (City, town, or county) (State)** *Balto Md*

**DATE RECEIVED BY LOCAL REGISTRAR** *AUG 11 1953* **REGISTRAR'S SIGNATURE** *William M.P.* **25. FUNERAL DIRECTOR** *Lemond J. Ruck* **ADDRESS** *5305 Hayford*

VS 150

Fady

Margorita

md.

Baltimore

Will Joppa Rd.

A. HATTIN

E. STEINWALKER

516  
53-7208BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7208

BIRTH NO. 23-17761

1. NAME OF DECEASED (Type or Print) <i>Imogene Baby Girl Chambers</i>		2. DATE OF DEATH <i>8-3-53</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>16-03</i>	
C. Length of stay in Baltimore <i>4</i> Yrs. <i>4</i> Mos. <i>Days</i>		D. STREET ADDRESS (If rural, give location) <i>909 N Tullon Ave</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>7-30-53</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>INFANT</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years, last birthday) <i>4</i>
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
13. FATHER'S NAME <i>Harold Dolkins</i>		14. MOTHER'S MAIDEN NAME <i>Addie? Chambers</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	

18. <i>768.5</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <i>Pustular skin infection</i> DUE TO (B) <i>Bacteremia</i> DUE TO (C) <i>Prematurity</i>	INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *8-3*, 19*53*, to *8-3*, 19*53*, that I last saw the deceased alive on *8-3*, 19*53*, and that death occurred at *8:30 Pm.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Virginia Hunter</i> M. D.	23B. ADDRESS <i>University Hospital</i>	23C. DATE SIGNED <i>8-4-53</i>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremated</i>	24B. DATE <i>8-12-53</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mague</i>	24D. LOCATION (City, town, or county) (State)
---	--------------------------	---	---

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <i>H. H. Hunter</i>	25. FUNERAL DIRECTOR <i>Huntington Williams, Jr.</i>	ADDRESS
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AUG 11 1953  
VS 150

1010

OFFICE OF THE ATTORNEY GENERAL

STATE OF NEW YORK

IN SENATE

JANUARY 10, 1910

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1909

ALBANY:

THE UNIVERSITY OF THE STATE OF NEW YORK

PRINTING OFFICE

1910



B-630  
3 7209

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7209

1. NAME OF DECEASED (Type or Print) <b>Leland Calvin Britt</b>		2. DATE OF DEATH <b>8/10/1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Balto.</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>719 Harlem Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write R.U.L. and give township) <b>17-03</b>	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>719 Harlem Ave.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Nov 2, 1924</b>
9. AGE (in years last birthday) <b>24</b>		10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Suffolk Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Vandious Britt</b>		14. MOTHER'S MAIDEN NAME <b>Menolia Magotto</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Eleonore Whitney</b>		ADDRESS <b>Suffolk Va.</b>	
18. <b>002X I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Tuberculosis</b> (A) DUE TO INTERVAL BETWEEN ONSET AND DEATH  ANTECEDENT CAUSES (B) DUE TO (C) DUE TO  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>7-8</b> 19 <b>53</b> to <b>8-10</b> 19 <b>53</b> that I last saw the deceased alive on <b>7-22</b> 19 <b>53</b> and that death occurred at <b>8:30 P.m.</b> from the causes and on the date stated above.			
23A. SIGNATURE <b>G. Franklin Phillips / P.C. Smith</b>		23B. ADDRESS <b>538 Mc Meheen St.</b>	
23C. DATE SIGNED <b>8-11-53</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/16/1953</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Walt Whitman</b>		24D. LOCATION (City, town, or county) (State) <b>Co-mo N.C.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 11 1953</b>		REGISTRAR'S SIGNATURE <b>Franklin Phillips</b>	
FUNERAL DIRECTOR <b>Walt Whitman</b>		ADDRESS <b>538 Mc Meheen St.</b>	

PLATO 10 10 10

RECEIVED BY THE SECRETARY OF THE  
NAVY DEPARTMENT  
WASHINGTON, D. C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **53 7210**

BIRTH NO. **53-10496**

1. NAME OF DECEASED  
(Type or Print)

**CRAIG WASHINGTON (SMITH)**

2. DATE  
OF  
DEATH

**July 17, 1953**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

**Maryland**

B. COUNTY

C. CITY OR TOWN

**Baltimore**

B. FULL NAME OF (If not in hospital or institution, give street address or location)

**Baltimore City Hospitals**

D. STREET ADDRESS (If rural, give location)

**1662 Bruce Court**

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

**Male**

6. COLOR OR RACE

**Colored**

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

**U**

9. AGE (In years last birthday)

If Under 1 Year  
Months: Days

**2**

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

**K**

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

**K**

14. MOTHER'S MAIDEN NAME

**O**

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

**N**

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

CAUSE OF DEATH

**DEHYDRATION AND MALNUTRITION**

DUE TO

ANTECEDENT CAUSES

(B)

**DIARRHEA**

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

**FATTY METAMORPHOSIS OF LIVER**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

**Joseph A. Jachimczyk M.D.**

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

**7-18-53**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Cremated**

24B. DATE

**8-10-53**

24C. NAME OF CEMETERY OR CREMATORY

**Moragne**

24D. LOCATION (City, town, or county)

**700 Fleet St.**

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**Huntington Williams**

25. FUNERAL DIRECTOR

**R. J. Fisher, M.D.**

ADDRESS



E-650

53 7211

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7211  
Registered No.

BIRTH NO. 53-18707

1. NAME OF DECEASED (Type or Print) <u>Shiela Ann Green</u>		2. DATE OF DEATH <u>8-9-53</u>	
3. PLACE OF DEATH: A. <u>Baltimore City, Maryland</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <u>Baltimore 23-02</u>	
5. Length of stay in Baltimore <u>2</u> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <u>36 E. Fort Ave.</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. DATE OF BIRTH <u>8-7-53</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME, <u>Eddie</u>		14. MOTHER'S MAIDEN NAME <u>Beatrice Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	

18. <u>762.5</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH  (A) <u>Atelectasis Neonatorum</u> DUE TO  (B) <u>Pulmonary congestion and edema</u> DUE TO  (C) <u>Prematurity</u>	INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION <u>2</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

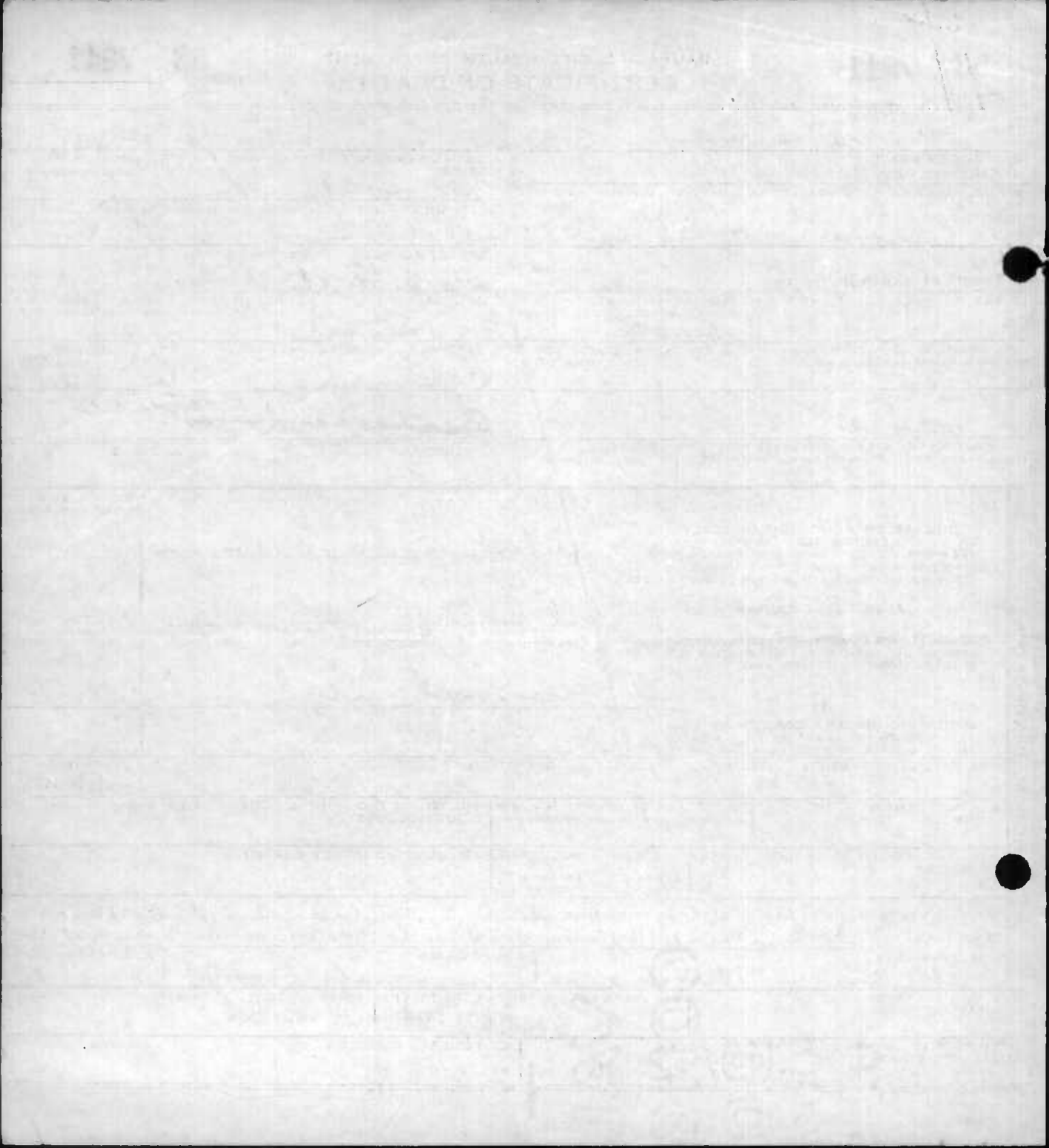
22. I hereby certify that I attended the deceased from 8-8, 1953, to 8-9, 1953, that I last saw the deceased alive on 8-9, 1953, and that death occurred at 5:15 Pm., from the causes and on the date stated above.

23A. SIGNATURE <u>Virginia Hunter</u> M. D.	23B. ADDRESS <u>University Hospital</u>	23C. DATE SIGNED <u>8-10-53</u>
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24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
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UNIVERSITY MEDICAL SCHOOL AUG 11 1953

DATE RECEIVED BY LOCAL REGISTRAR <u>AUG 12 1953</u>	REGISTRAR'S SIGNATURE <u>Huntington Williams, M.D.</u>	25. FUNERAL DIRECTOR <u>Huntington Williams, M.D.</u>	ADDRESS
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M-450

53 7212

## BALTIMORE CITY HEALTH DEPARTMENT

53 7212

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

53-17767

1. NAME OF DECEASED  
(Type or Print)

Baby Girl Mullen

2. DATE  
OF  
DEATH

8-5-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Univ. Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

University Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

15-01

D. STREET ADDRESS (If rural, give location)

1317 N Stricker

#17

E. Length of stay in Baltimore

4 Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Baby

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

8. DATE OF BIRTH

8-1-53

9. AGE (In years  
last birthday)11 Under 1 Year  
Months Days Hours Min.

4

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

George

14. MOTHER'S MAIDEN NAME

Doris

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

## CAUSE OF DEATH

18. 776X I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATHOTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-1-53, 1953, to 8-5-1953 that I last saw the  
deceased alive on 8-5-1953, and that death occurred at 6:45 a.m., from the causes and on the date stated above.

23A. SIGNATURE

W. L. Heimer

M. D.

23B. ADDRESS

University Hospital

23C. DATE SIGNED

8-5-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL AUG 11 1953

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 12 1953

H. J. Taylor

7 Dwight Street

Williams, Md.

255

RECEIVED  
OFFICE OF THE  
SECRETARY OF THE  
NAVY  
WASHINGTON, D. C.

256

5



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7213

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7213  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BEAUFORD SANDERS</b>		2. DATE OF DEATH <b>July 20, 1953</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Ohio</b> B. COUNTY <b>V-22</b>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Cleveland</b>			
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>2538 E. 59th Street</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <b>U</b>	9. AGE (In years last birthday) <b>20</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>K</b>	
13. FATHER'S NAME <b>N</b>		14. MOTHER'S MAIDEN NAME <b>O</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>W</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>N</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>N E 984X</b> <b>Gunshot wound of the aorta</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>1810 Broening Highway</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>7-20-53 4:15 A.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>shot during burglary attempt</b>	
22. I certify that I took charge of the remains described above, held an <b>autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>R. Fisher</b>		23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>7-20-53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <b>UNIVERSITY MEDICAL SCHOOL</b>	
24D. LOCATION (City, town, or county) (State)		24E. DATE <b>AUG 11 1953</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 12 1953</b>		REGISTRAR'S SIGNATURE <b>H. Williams</b>		25. FUNERAL DIRECTOR <b>H. Williams</b>	
ADDRESS		ADDRESS <b>H. Williams</b>			

8257 82

8257 82

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

OFFICE OF THE ASSISTANT ATTORNEY GENERAL

WASHINGTON, D. C.

WASHINGTON, D. C.

UNITED STATES DEPARTMENT OF THE INTERIOR

Washington, D. C.

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT



UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON, D. C.

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

53 7214

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7214

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mc Nichols, Theresa Rachel

2. DATE  
OF  
DEATH August 11, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

St. Joseph's Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

719 N. Luzerne Avenue

C. Length of stay in Baltimore

2 days

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

August 9, 1953

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

2

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Francis McNichols

14. MOTHER'S MAIDEN NAME

Barbara Ellen Mullins

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 762.5 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Sclerema and atelectasis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Prematurity

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 9, 1953, to August 11, 1953, that I last saw the  
deceased alive on August 11, 1953, and that death occurred at 2:55 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

1957 84

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

1957 84

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5-345

53 7215

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7215

BIRTH NO.

1. NAME OF DECEASED (Type or Print) *Jack G. Stulman*

2. DATE OF DEATH *August 10/53*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE *Maryland* B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION *Mercy Hospital*

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) *Baltimore*

7. STREET ADDRESS (If rural, give location) *3637 Dolfield Avenue*

8. Length of stay in Baltimore *Life* Yrs. Mos. Days

9. SEX *Male*

10. COLOR OR RACE *White*

11. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) *Married*

12. DATE OF BIRTH *July 11, 1911*

13. AGE (In years last birthday) *42*

14. If Under 1 Year Months: Days

15. If Under 24 Hours Hours: Min.

16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Salesman*

17. KIND OF BUSINESS OR INDUSTRY *Clothing (mens)*

18. BIRTHPLACE (State or foreign country) *Baltimore, Md*

19. CITIZEN OF WHAT COUNTRY? *USA*

20. FATHER'S NAME *Late Louis Stulman*

21. MOTHER'S MAIDEN NAME *Jeannette Rosdy*

22. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

23. SOCIAL SECURITY NO.

24. INFORMANT ADDRESS *Mildred Stulman - 3637 Dolfield*

18. *420.1* CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Coronary Occlusion* DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Myocardial Infarction* DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH *1 hr.*

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *July 1, 1953*, to *August 10, 1953*, that I last saw the deceased alive on *July 31, 1953*, and that death occurred at *4 P. m.*, from the causes and on the date stated above.

23A. SIGNATURE *Joseph R. Mierowicz* M. D.

23B. ADDRESS *5145 Park Heights Ave*

23C. DATE SIGNED *8/10/53*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE *8/12/53*

24C. NAME OF CEMETERY OR CREMATORY *Hebrew Friendship*

24D. LOCATION (City, town, or county) (State) *Baltimore, Md.*

DATE RECEIVED BY LOCAL REGISTRAR *AUG 12 1953*

REGISTRAR'S SIGNATURE *Huntington Williams*

25. FUNERAL DIRECTOR ADDRESS *Bob Levinson - Broa - 1124-26 W. North Ave*

VS 150

4906E

1883

1883

M-460

53 7216

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7216

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Yetta Miller

2. DATE  
OF  
DEATH

Aug 12/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

2621 Quantic Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

15-13

C. Length of stay in Baltimore

45 yrs.

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

2621 Quantic Avenue

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

1876

9. AGE (In years  
last birthday)

77

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

own Home

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Ma. Louis Levine - 2807 Quantic Ave

18. 420.1 and 260X  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

Coronary thrombosis

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

1 hour

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Arterio-sclerosis

DUE TO

10 years

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes mellitus

10 years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., In or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1942 to 8/12/1953, 1953 that I last saw the  
deceased alive on 8/12/53, 1953, and that death occurred at 3:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Jack Cohen

23B. ADDRESS

M. D.

1804 Guntaw Place

23C. DATE SIGNED

8/12/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

8/13/53

24C. NAME OF CEMETERY OR CREMATORY

Agudas Achem Bldg., Baltimore, Md

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 12 1953

H. E. Williams, M.D. &amp; Sons - 1124-26 W. North Ave

3150 37

RECEIVED BY THE DEPARTMENT OF THE ARMY

OFFICE OF THE CHIEF OF STAFF

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OFFICE OF THE CHIEF OF STAFF  
WASHINGTON, D. C.  
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OFFICE OF THE CHIEF OF STAFF  
WASHINGTON, D. C.  
JAN 10 1918

RECEIVED BY THE DEPARTMENT OF THE ARMY

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

53 7217  
Registered No.

53 7217  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Mabel A. Dove</i>			2. DATE OF DEATH <i>Aug. 11<sup>th</sup> 1953</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>12-01</i>		
5. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Guilford Manor Apts</i> <i>2 W. University Parkway</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>		
6. LENGTH OF STAY IN BALTIMORE <i>Life</i>			D. STREET ADDRESS (If rural, give location) <i>Guilford Manor Apts</i> <i>2 W. University Parkway</i>		
7. SEX <i>Female</i>	8. COLOR OR RACE <i>White</i>	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	10. DATE OF BIRTH <i>Aug. 25, 1878</i>		11. AGE (in years last birthday) <i>74</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Goldman Guber</i>			14. MOTHER'S MAIDEN NAME <i>Ellen March</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>No</i>		
17. INFORMANT <i>Mrs. John B. Add</i>			ADDRESS <i>Guilford Manor Apts</i> <i>2 W. University Parkway</i>		

18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Occlusion</i> <i>Cardio-Renal-Hypertensive Disease</i> <i>Rheumatoid Arthritis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>10 yrs.</i> <i>10 yrs.</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *March 29, 1953* to *Aug 11, 1953* that I last saw the deceased alive on *Aug 11, 1953* and that death occurred at *7:10 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE <i>J M Wilson</i>		23B. ADDRESS <i>617 W. 40th St</i>		23C. DATE SIGNED <i>8/11/53</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	24B. DATE <i>Aug. 12, 1953</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>Aug 12 1953</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>		MUNICIPAL DIRECTOR <i>Quigley</i>
				ADDRESS <i>4510 Liberty Heights Ave.</i>

MEDICAL CERTIFICATION

1957

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ORIGINAL DATE 1957

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5-625  
53 7219BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7219

BIRTH NO.

1. NAME OF DECEASED (Type or Print) *David SIKKIN* 2. DATE OF DEATH *8/11/1953*3. PLACE OF DEATH: A. Baltimore City, Maryland 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE *Md.* B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location) C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Sinai Hospital* *Balto. 16 15-06*D. STREET ADDRESS (If rural, give location) *3118 W. North Ave.*Length of stay in Baltimore *50* Yrs. *Mon* Days5. SEX *M* 6. COLOR OR RACE *W* 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) *M* 8. DATE OF BIRTH *—* 9. AGE (In years last birthday) *56* 10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min:10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *merchant* 10B. KIND OF BUSINESS OR INDUSTRY *Haberdashery* 11. BIRTHPLACE (State or foreign country) *Russia* 12. CITIZEN OF WHAT COUNTRY?13. FATHER'S NAME *Abraham* 14. MOTHER'S MAIDEN NAME *Lease*15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT *Leah Sirkine - Danner* ADDRESS18. *420.1 I* CAUSE OF DEATH *Acute myocardial infarction* INTERVAL BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) *acute myocardial infarction*DUE TO (B) *acute coronary thrombosis*(C) *arteriosclerotic coronary disease*

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?22. I hereby certify that I attended the deceased from *8/10* 19*53*, to *8/11* 19*53*, that I last saw the deceased alive on *8/11* 19*53*, and that death occurred at *3:35* p. m., from the causes and on the date stated above.23A. SIGNATURE *E. Chelminsky* M. D. 23B. ADDRESS *Sinai Hospital* 23C. DATE SIGNED *8/11/1953*24A. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 24B. DATE *8-12-53* 24C. NAME OF CEMETERY OR CREMATORY *Rosedale* 24D. LOCATION (City, town, or county) (State) *Balto Md*DATE RECEIVED BY LOCAL REGISTRAR *AUG 12 1953* REGISTRAR'S SIGNATURE *Huntington Williams* 25. FUNERAL DIRECTOR *2100 Eutan Pl* ADDRESS

VS 150 2906E

USE

42

RECEIVED

DATE

NO

1952

RECEIVED

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RECEIVED

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

R-400  
53 7220

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

53 7220

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

ELIAS B. KAL

2. DATE  
OF  
DEATH

AUG 11 1953

3. PLACE OF DEATH:

a. Baltimore City, Maryland

Med. Dept.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE

b. COUNTY

b. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Norfolk

d. STREET ADDRESS (If rural, give location)

1258 Jennifer St.

33  
c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

8-14-21

9. AGE (In years, last birthday)

31

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Insurance Agent

10b. KIND OF BUSINESS OR INDUSTRY

Union Lf. Ins. Co.

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Bechara H. Kal

14. MOTHER'S MAIDEN NAME

Frances Habibi

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

yes

W.W. II

16. SOCIAL SECURITY NO.

JOHNS HOPKINS HOSPITAL

ADDRESS

18.

443X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ..... Uremia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ..... Hypertensive vascular disease

DUE TO

(C) .....

INTERVAL BETWEEN ONSET AND DEATH

2 wks.

5 yrs.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-15-1953 to 8-11-1953 that I last saw the deceased alive on 8-11-1953, and that death occurred at 104 A.M., from the causes and on the date stated above.

23a. SIGNATURE

John L. Hedeman

23b. ADDRESS

JOHNS HOPKINS HOSPITAL

23c. DATE SIGNED

8-11-53

24a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24b. DATE

8/12/53

24c. NAME OF CEMETERY OR CREMATORY

Forrest Lawn Cemetery, Norfolk, Virginia

24d. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 12 1953

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Am. Book, Inc., 1217 St. Paul St.

ADDRESS

VS 150

45073

1950

1950

1950

VALLEY  
CONGRESS

DO

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1950



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

15-655  
53 7221

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7221  
Registered No.

1. NAME OF DECEASED (Type or Print)			2. DATE OF DEATH		
MINNIE L. KIERNAN			August 10, 1953		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
B. FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital			A. STATE Maryland		
C. Length of stay in Baltimore			B. COUNTY		
5. SEX Female			C. CITY OR TOWN Baltimore		
6. COLOR OR RACE White			D. STREET ADDRESS (If rural, give location) 509 W. 28th Street		
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed			8. DATE OF BIRTH May 11, 1868		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			9. AGE (In years last birthday) 85		
10B. KIND OF BUSINESS OR INDUSTRY own home			11. BIRTHPLACE (State or foreign country) Columbia County, New York		
13. FATHER'S NAME Walter R. Decker			12. CITIZEN OF WHAT COUNTRY?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			14. MOTHER'S MAIDEN NAME Isabel Wise		
16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Fred Bardeen, Hornell, New York		

18. 334X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Arteriosclerotic cerebrovascular disease DUE TO (B) DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that I took charge of the remains described above, held an inspection & inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .						
23A. SIGNATURE Joseph G. Jackson, Jr.		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED August 11, 1953		
24A. BURIAL, CREMATION, REMOVAL (Specify) removal		24B. DATE 8/12/53		24C. NAME OF CEMETERY OR CREMATORY Hudson		
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE Huntington Williams		24D. LOCATION (City, town, or county) (State) Hudson, New York		
AUG 12 1953		25. FUNERAL DIRECTOR Wm. Cook, Inc.		ADDRESS 1217 St. Paul Street		

ISSN

02

ISSN

02

53 7222

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7222  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary C. Ritter

2. DATE  
OF  
DEATH

8-10-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Balto

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

2102 Fleet Street

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

Md.

B. COUNTY

C. CITY OR TOWN

Baltimore, Md.

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

2102 Fleet Street

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

13. FATHER'S NAME

Wm/Henry Young

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

7-30-66

9. AGE (in years last birthday)

87

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Harriett ?

17. INFORMANT

Mrs Rhoda Thomas

ADDRESS

same

18. 794X I CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) .....  
DUE TO

Senility

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) .....  
DUE TO  
(C) .....INTERVAL BETWEEN  
ONSET AND DEATH

years

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 14, 1949, to Aug. 8, 1953, that I last saw the deceased alive on Aug. 8, 1953, and that death occurred at 7:45 P.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-14-53

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn

24D. LOCATION (City, town, or county)

Baltimore Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 12 1953

Huntington Williams, M.D.

Lilly &amp; Zeiler, Inc. 403 S. Wolfe Street

VS 150

MEDICAL CERTIFICATION



M-245

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7223

Registered No. \_\_\_\_\_

53 7223  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>John F. Myslinski</i>			2. DATE OF DEATH <i>Aug. 9, 1953</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>1-01</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>913 S. Patomac St.</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baets.</i>		
C. Length of stay in Baltimore <i>?</i>			D. STREET ADDRESS (If rural, give location) <i>913 S. Patomac St.</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>12-28-1880</i>		9. AGE (In years last birthday) <i>73</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Roundel Exp.</i>	11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Jacob Myslinski</i>			14. MOTHER'S MAIDEN NAME <i>Katherine Grezouk</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>217-16-1820</i>		
			17. INFORMANT ADDRESS <i>Mrs. Stella Myslinski</i>		

18. <i>446X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) <i>Acute nephritis</i>		DUE TO		<i>10 days</i>	
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) <i>Distal nephrosis</i>		<i>1</i>	
		DUE TO			
		(C) <i>Bacterial pneumonia</i>		<i>3 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *Aug 6, 1953*, to *Aug 9, 1953*, that I last saw the deceased alive on *Aug 9, 1953* and that death occurred at *9:00 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Geo W. Lippert</i>		23B. ADDRESS <i>46 S. Patomac Ph. Av.</i>		23C. DATE SIGNED <i>8/11/53</i>	
---	--	--	--	------------------------------------	--

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Aug. 13, 1953</i>		24C. NAME OF CEMETERY OR CREMATORY <i>St. Stanislaus</i>		24D. LOCATION (City, town, or county) (State) <i>Dundock Ave. Md.</i>	
--	--	-----------------------------------	--	---	--	--	--

DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 12 1953</i>		REGISTRAR'S SIGNATURE <i>Huntington</i>		25. FUNERAL DIRECTOR <i>John J. Duda Inc. 2829 Submont.</i>		ADDRESS <i>51024</i>	
--	--	--	--	--	--	-------------------------	--

1911



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7224  
Registered No.

153 7224  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Stanislawa Krac</i>		2. DATE OF DEATH <i>Aug. 10/53</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>234 W. Chapel St</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>2-01</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION		D. STREET ADDRESS (If rural, give location) <i>234 W Chapel St</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>		8. DATE OF BIRTH <i>Sept. 59</i>	
9. AGE (in years, last birthday) <i>59</i>		10. UNDER 1 Year Months: Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Nowakowski</i>		14. MOTHER'S MAIDEN NAME <i>Gint</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Walter Krac</i>		ADDRESS	

18. <i>E 903.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Myocardial infarction</i>		CAUSE OF DEATH <i>Myocardial infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO <i>Myocardial infarction</i>		(B) DUE TO <i>Myocardial infarction</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CERTIFICATION APPROVED BY <i>Joseph A. Jachimczyk</i> M.D. CHIEF OR ASST. MEDICAL EXAMINER.		(C) DUE TO	

19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <i>home</i>		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <i>434 W Chapel St</i>		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>May 10 1953</i>	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>accidental fall</i>		22. I hereby certify that I attended the deceased from <i>Aug. 3, 1953</i> to <i>Aug 10, 1953</i> that I last saw the deceased alive on <i>Aug 10, 1953</i> , and that death occurred at <i>7P</i> m., from the causes and on the date stated above.		23A. SIGNATURE <i>Frank Jachimczyk</i> M.D.	
23B. ADDRESS <i>2003 East 8th St</i>		23C. DATE SIGNED <i>8/11/53</i>		24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Aug 14/53</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Holy Rosary</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>		25. FUNERAL DIRECTOR <i>Fred W. Ozasowski</i>		ADDRESS <i>1980 Eastern Ave.</i>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		26. APPROVED BY MEDICAL EXAMINER		VS 100	

1957 82

1957 8

UNITED STATES DEPARTMENT OF AGRICULTURE

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES

RUCKER

2. DATE  
OF  
DEATH

July 9, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF not in hospital or institution, give street address or location  
HOSPITAL OR INSTITUTION Franklin Square Hospital4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
BaltimoreD. STREET ADDRESS (If rural, give location)  
1309 Lemmon Street

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

U

9. AGE (In years  
last birthday)

60

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
N10B. KIND OF BUSINESS OR  
INDUSTRY11. BIRTHPLACE (State or foreign country)  
K12. CITIZEN OF  
WHAT COUNTRY?13. FATHER'S NAME  
N14. MOTHER'S MAIDEN NAME  
O15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT  
N

ADDRESS

18.

422.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, assthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

## ANTECEDENT CAUSES

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an inspection & inquiry thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Joseph A. Gachinski

M.D.

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

6-10-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 12 1953  
VS 151

H. J. F. 319-200 22.2 Thompson Williams, M.D.

UNIVERSITY MEDICAL SCHOOL AUG 11 1953

03 555

03 555



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7226

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7226

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
NELLIE MAY CATHCART		Aug. 10, 1953	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
B. FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE	
4307 Elderon Ave.		Md.	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		B. COUNTY	
Baltimore		28-41	
D. STREET ADDRESS (If rural, give location)		4307 Elderon Ave.	
c. Length of stay in Baltimore		Yrs. Mos. Days	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
Female	White	Single	Feb. 12, 1875
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday)
Retired Sect'y		Paper Tube Business	78
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Balto. Md.		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Aaron Cathcart		Mary Jett Gilbert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
No		?	
17. INFORMANT		ADDRESS	
Mrs. Jettie Evens		15 W. Bury Ave. N. Y. West. Brighton Station Is.	

18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) DUE TO		Right Hemiplegia			
ANTECEDENT CAUSES		(B) DUE TO		Chronic Myocarditis	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) DUE TO		Hypertension	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug. 9, 1953 to Aug 10, 1953, that I last saw the deceased alive on Aug 10, 1953 and that death occurred at 2:40 P. M., from the causes and on the date stated above.							
23A. SIGNATURE				23B. ADDRESS		23C. DATE SIGNED	
George E. Shannon MD				P 20 medical & Bldg		8/11/53	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/13/53		Loudon Park		Baltimore, Md.	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR		ADDRESS	
AUG 12 1953		Huntington, Williams, Mr		Wm J. Jackson & Sons		Balto Md.	

1956



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

53 7287  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Wilbur F. Hendricks

2. DATE  
OF  
DEATH

Aug. 8/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

720 McCabe Ave.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE  
B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

720 McCabe Ave

c. Length of stay in Baltimore

55 yrs

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 14, 1884

9. AGE (In years last birthday)

69

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Conductor

10B. KIND OF BUSINESS OR INDUSTRY

B. & O. R. R.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William A. Hendricks

14. MOTHER'S MAIDEN NAME

Mollie Wall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Caroline M. Hendricks

18. 420.0 I

CAUSE OF DEATH 720 McCabe Ave

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) *arteriosclerotic*  
DUE TO  
*Heart Disease - Coronary*  
(B) *insufficiency*  
DUE TO  
(C) \_\_\_\_\_

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Aug 1, 1953 to Aug 8, 1953, that I last saw the deceased alive on Aug 8, 1953, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

Aug. 12/53

Mt. Olivet

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 12 1953

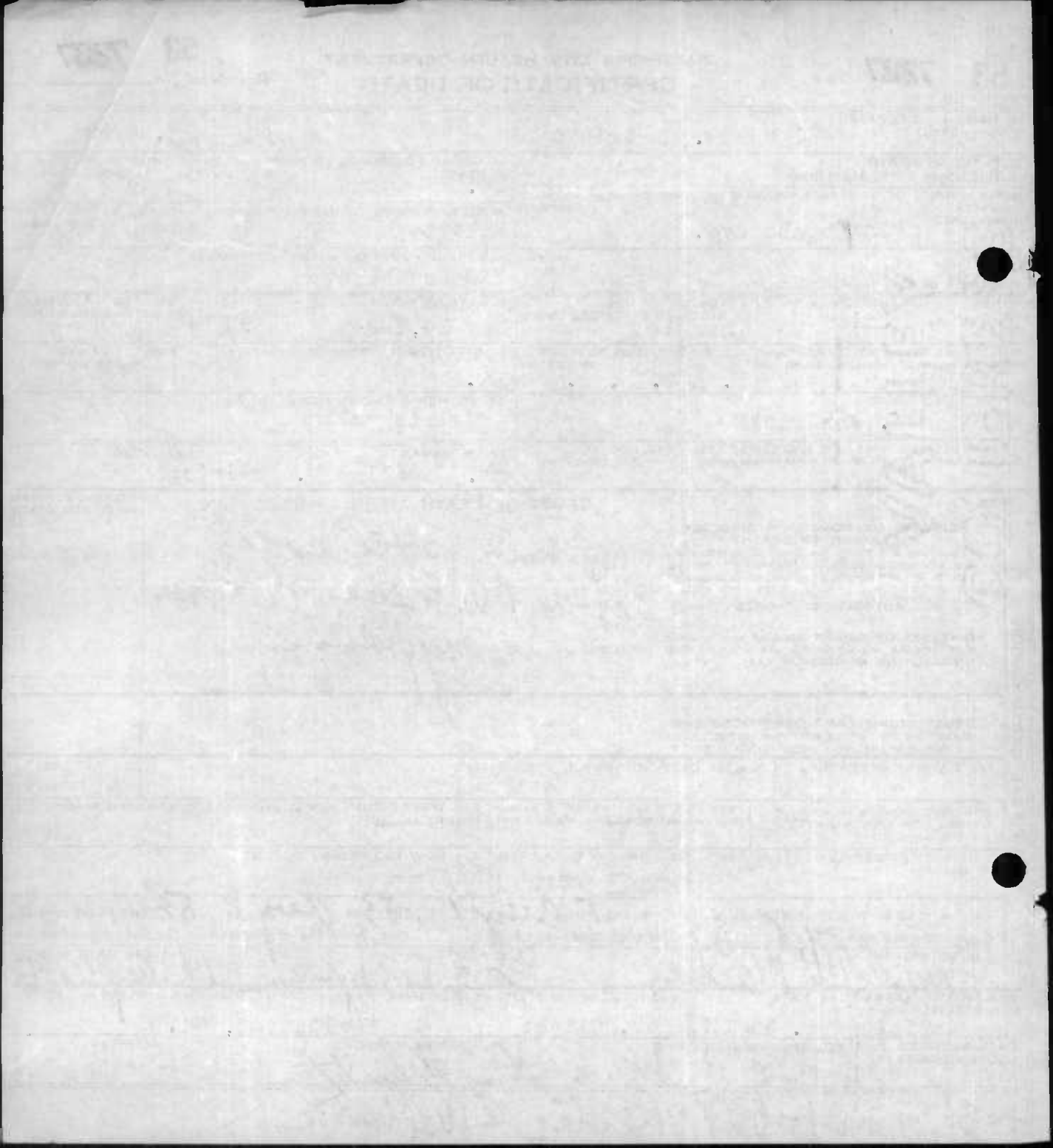
Huntington William A. Hendricks

4101 Edmondson Ave

VS 150

\* Pt. of Dr Robert Renter L. Walbrook 203 50

MEDICAL CERTIFICATION



M-2-00

53 7228

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7228  
Registered No.

1. NAME OF DECEASED (Type or Print) IDA MARY MEISE		2. DATE OF DEATH August 9. 1953	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY	
5. FULL NAME OF (If not in hospital or institution, give street address or location) HILTON NURSING HOME 3520 Hilton St.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-02	
6. LENGTH OF STAY IN BALTIMORE 70 yrs		D. STREET ADDRESS (If rural, give location) 3021 Abell Avenue	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Aug. 22. 1865
9. AGE (In years last birthday) 87		10. UNDER 1 YEAR Months: Days: Hours: Min.	11. UNDER 24 HOURS Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) Harford County Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Shadrach Streett		14. MOTHER'S MAIDEN NAME Julia Ann Wright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT ADDRESS Mrs. Myrtle Meise Seward (Daughter) 3021 Abell Ave			
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cerebral Vascular Accident DUE TO (B) arteriosclerosis DUE TO (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH 4 wks 15 yrs	
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1931, 19, to 8/9/53, 19, that I last saw the deceased alive on 8/8/53, 19, and that death occurred at 7:45 a. m., from the causes and on the date stated above.			
23A. SIGNATURE Francis M. Gluck		23B. ADDRESS 100 W University Pkwy	
23C. DATE SIGNED 8/10/53			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 12. 1953	
24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
DATE RECEIVED BY LOCAL REGISTRAR AUG 12 1953		25. FUNERAL DIRECTOR HENRY SANDER & SONS, INC. Baltimore Md.	
VS 150		26. ADDRESS Seery A. Sander.	

MEDICAL CERTIFICATION



M-532

53 7229

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7229  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>HENRY A. MONTGOMERY</b>		2. DATE OF DEATH <b>AUG 9, 1953</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland <b>YES</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>8</b>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE -13 8-01</b>	
6. Length of stay in Baltimore <b>ENTIRE LIFE</b>		d. STREET ADDRESS (If rural, give location) <b>3127 MARECO AVE. BALTO. 13, MD.</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>MAY 6, 1893</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC Foreman Standard Oil Co</b>		9. AGE (In years last birthday) <b>60</b>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>ELIGAH B. MONTGOMERY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>SARAH ANDREWS</b>	
16. SOCIAL SECURITY NO. <b>213-05-8292</b>		17. INFORMANT ADDRESS <b>MAUDE MONTGOMERY 3127 MARECO AVE.</b>	
18. <b>581.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>HEPATIC INSUFFICIENCY</b> DUE TO <b>LAENNEC'S CIRRHOSIS</b> DUE TO <b>ARTERIOSCLEROTIC HEART DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>8/24</b> , 19 <b>53</b> to <b>8/9</b> , 19 <b>53</b> that I last saw the deceased alive on <b>8/9</b> , 19 <b>53</b> and that death occurred at <b>9:30 p.m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Carl E. Spruill, M.D.</b>		23B. ADDRESS <b>UMH</b>	
23C. DATE SIGNED <b>8/9/53</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Aug 13, 1953</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Pk</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	25. FUNERAL DIRECTOR ADDRESS <b>HENRY SANDER &amp; SONS, INC. 7 BALTIMORE, MARYLAND</b>	

VS 150

52345

Sey? Menden.

MEDICAL CERTIFICATION

1550

UNITED STATES DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1550

2

NAME

John

AGE

SEX

RACE

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

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C-652

CHARMES

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7230  
BIRTH NO.53 7230  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>George E. Charmes</i>		2. DATE OF DEATH <i>8-11-53</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>1370 N. Fremont Ave.</i> B. COUNTY <i>Baltimore</i>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>1370 N. Fremont Ave.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore, Md.</i>	
6. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <i>1501</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>C.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>Aug 13 - 1896</i>
9. AGE (in years last birthday) <i>56</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Henry Charmes</i>	
14. MOTHER'S MAIDEN NAME <i>Rachel Berry</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Alice M. Johnson</i>	
18. ADDRESS <i>812 W. Lanvale St.</i>			

18. 002X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <i>Pulmonary Tuberculosis</i>	INTERVAL BETWEEN ONSET AND DEATH
DUE TO		(A)	
DUE TO		(B)	
DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION <i>0</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *7-25*, 19*53* to *8-11*, 19*53*; that I last saw the deceased alive on *8-11*, 19*53*, and that death occurred at *3:30* p.m., from the causes and on the date stated above.

23A. SIGNATURE <i>Herford P. ...</i>	23B. ADDRESS <i>2309 ...</i>	23C. DATE SIGNED <i>8-12-53</i>
---	---------------------------------	------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <i>8-13-53</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Piney Grove</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore Co. Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 12 1953</i>	REGISTRAR'S SIGNATURE <i>Huntington Williams</i>	25. FUNERAL DIRECTOR <i>W. Biddle</i>	ADDRESS <i>578</i>

97099

MEDICAL CERTIFICATION

0830 38

0830 38

CERTIFICATE OF DEATH

1. Name of deceased John Doe  
2. Sex Male  
3. Age 45  
4. Date of birth 10/15/1930  
5. Place of birth New York, N.Y.

6. Date of death 11/10/1975  
7. Place of death New York, N.Y.  
8. Cause of death Heart Disease

9. Signature of physician [Signature]  
10. Signature of registrar [Signature]

11. Signature of informant [Signature]

12. Signature of funeral director [Signature]

13. Signature of medical examiner [Signature]

14. Signature of coroner [Signature]

15. Signature of health officer [Signature]

16. Signature of registrar [Signature]

17. Signature of informant [Signature]

53 7231

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7231

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF

HOSPITAL OR

INSTITUTION

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
A. STATE B. COUNTY before admission)

1517 Madison Ave Baltimore City

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore, Md 11-09

D. STREET ADDRESS (If rural, give location)

1017 Madison Ave

8. DATE OF BIRTH

July 27, 1888

9. AGE (In years  
last birthday)

65

H Under 1 Year

Months: 0 Days: 19 Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

18. 42011

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

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## CAUSE OF DEATH

(A) Coronary Occlusion

(B) Coronary Occlusion

(C) Coronary Occlusion

(D) Coronary Occlusion

(E) Coronary Occlusion

(F) Coronary Occlusion

(G) Coronary Occlusion

(H) Coronary Occlusion

(I) Coronary Occlusion

(J) Coronary Occlusion

(K) Coronary Occlusion

(L) Coronary Occlusion

(M) Coronary Occlusion

(N) Coronary Occlusion

(O) Coronary Occlusion

(P) Coronary Occlusion

(Q) Coronary Occlusion

(R) Coronary Occlusion

(S) Coronary Occlusion

(T) Coronary Occlusion

(U) Coronary Occlusion

(V) Coronary Occlusion

(W) Coronary Occlusion

(X) Coronary Occlusion

(Y) Coronary Occlusion

(Z) Coronary Occlusion

(AA) Coronary Occlusion

(AB) Coronary Occlusion

(AC) Coronary Occlusion

INTERVAL BETWEEN  
ONSET AND DEATH

Interval between onset and death

Interval between onset and death

Interval between onset and death

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19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 11, 1953, to Aug 11, 1953, that I last saw the  
deceased alive on Aug 11, 1953, and that death occurred at 12:00 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

23D. SIGNATURE

23E. ADDRESS

23F. DATE SIGNED

23G. SIGNATURE

23H. ADDRESS

23I. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

25. FUNERAL DIRECTOR

ADDRESS

Received of the  
Hon. Secy of the  
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for the  
Department of the  
Interior  
the sum of  
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B-650

53 7232

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7232

Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Make Brown</b>		2. DATE OF DEATH <b>8/11/53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>St. Joseph Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>7-05</b>			
C. Length of stay in Baltimore <b>20 yrs.</b>		D. STREET ADDRESS (If rural, give location) <b>1922 E. Jefferson St.</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>black</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>separated</b>	8. DATE OF BIRTH <b>7/1/02</b>	9. AGE (in years last birthday) <b>51</b>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N. Carolina</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Malcolm Brown</b>		14. MOTHER'S MAIDEN NAME <b>Mary</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mary Ray 1922 Jefferson St</b> ADDRESS	
18. <b>199.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) <b>Generalized Carcinomatosis</b>		DUE TO			
ANTECEDENT CAUSES		(B) <b>Primary unknown</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>8/7 - 8/11/53</b>		19B. MAJOR FINDINGS OF OPERATION <b>Abdomen was not opened due to patient's poor condition.</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.					
23A. SIGNATURE <b>B. B. Teles</b>		23B. ADDRESS		23C. DATE SIGNED	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>Aug 14/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem</b>	
24D. LOCATION (City, town, or county) (State) <b>A.A. County Md</b>		25. FUNERAL DIRECTOR <b>Mrs. R. A. Elliott &amp; Daughter</b>		ADDRESS <b>95099 11277 Caroline St.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 12 1953</b>		REGISTRAR'S SIGNATURE <b>H. E. Jones</b>		VS 150	

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

10-10-50

10-10-50

10-10-50

10-10-50

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

10-10-50

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

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UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

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UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

10-10-50

10-10-50

10-10-50



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7233

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIE THOMAS

2. DATE  
OF  
DEATH

8/9/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

University Hosp.

C. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

B

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widower

8. DATE OF BIRTH

6/27/92

9. AGE (In years last birthday)

62

10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Construction

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ala.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Ketchen Thomas

14. MOTHER'S MAIDEN NAME

Angelie Barnett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Daughter

ADDRESS

18. 422.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic Cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Perineural abscess

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/3, 1953, to 8/9, 1953, that I last saw the deceased alive on 8/9, 1953, and that death occurred at 5:00 P m., from the causes and on the date stated above.

23. SIGNATURE

John B. Codrington

M. D.

23B. ADDRESS

University Hosp.

23C. DATE SIGNED

8/9/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

Interred

24B. DATE

8/13/1953

24C. NAME OF CEMETERY OR CREMATORY

Opelika

24D. LOCATION (City, town, or county) (State)

Opelika Ala.

DATE RECEIVED BY LOCAL REGISTRAR

AUG 12 1953

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

McKee Williams & Schenck

ADDRESS

322



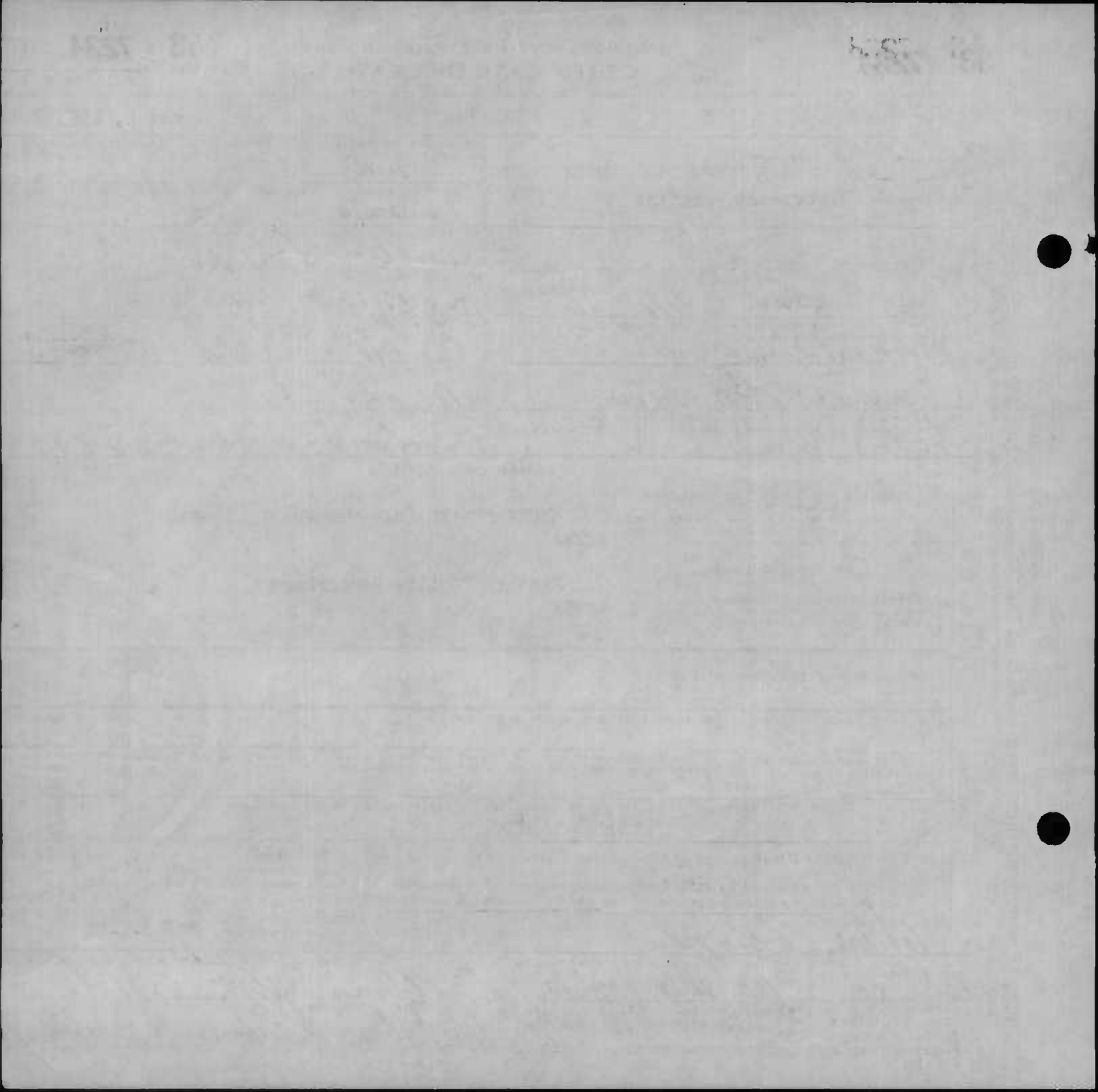
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7234

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7234  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ROY MC KINZIE		2. DATE OF DEATH August 4, 1953	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland		B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 1619 Druid Hill Ave.	
c. Length of stay in Baltimore		5. SEX male		6. COLOR OR RACE colored	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE		8. DATE OF BIRTH Aug 31, 1918		9. AGE (In years last birthday) 34	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant Marine		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cuba	
13. FATHER'S NAME Samuel McKenzie		14. MOTHER'S MAIDEN NAME Ailes		12. CITIZEN OF WHAT COUNTRY? C	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.II		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Rachel Jordan 130 W. 142 St NYC	
18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertensive Cardiovascular Disease XXXXXX		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Massive Pontine Hemorrhage XXXXXX DUE TO		(B)		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .					
23A. SIGNATURE William H. Roberts		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED 8-4-53	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/13/1953		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. Baltimore	
DATE RECEIVED BY LOCAL REGISTRAR AUG 12 1953		REGISTRAR'S SIGNATURE Huntington Williams		24D. LOCATION (City, town, or county) (State) H.A.	
VS 151		25. FUNERAL DIRECTOR Wm. R. Williams		ADDRESS 322	

67355



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7235

BIRTH NO. 53 7235

1. NAME OF DECEASED  
(Type or Print) DAVID R. GIBSON

2. DATE OF DEATH Aug. 9, 1953

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Balto. 25-52

907 Coppin Ct

D. STREET ADDRESS (If rural, give location)  
907 Coppin Ct.

C. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday) If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 763.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) INTERSTITIAL PNEUMONITIS

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

8-9-53

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

1887 82

THE NEW YORK PUBLIC LIBRARY

ASTOR LENOX TILDEN FOUNDATION

1887 82

1887 82

1887 82





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-430  
7236

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7236  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Georgia Holt

2. DATE  
OF  
DEATH

Aug 10, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Med. Dept. 4

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN

(If outside corporate limits, write full name and give township)

D. STREET ADDRESS (If rural, give location)

1605 Riggs Ave

5. Length of stay in Baltimore

Yrs.  
Mos.  
Days

6. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Geo. Washington

14. MOTHER'S MAIDEN NAME

Elizabeth Rawlins

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 330X 1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) ...

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) ...

DUE TO

(C) ...

Sub-arachnoid hemorrhage 12 hrs

Hypertension

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH. ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-9-1953 to 8-10-1953, that I last saw the  
deceased alive on 8-10-1953 and that death occurred at 9:40 a.m. from the causes and on the date stated above.

23A. SIGNATURE

Vernon H. Wagner

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

8/10/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 12 1953

Huntington Williams, M.D. 8229

STATE OF TEXAS

County of \_\_\_\_\_

1004846

WATKINS

CONTRACTS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

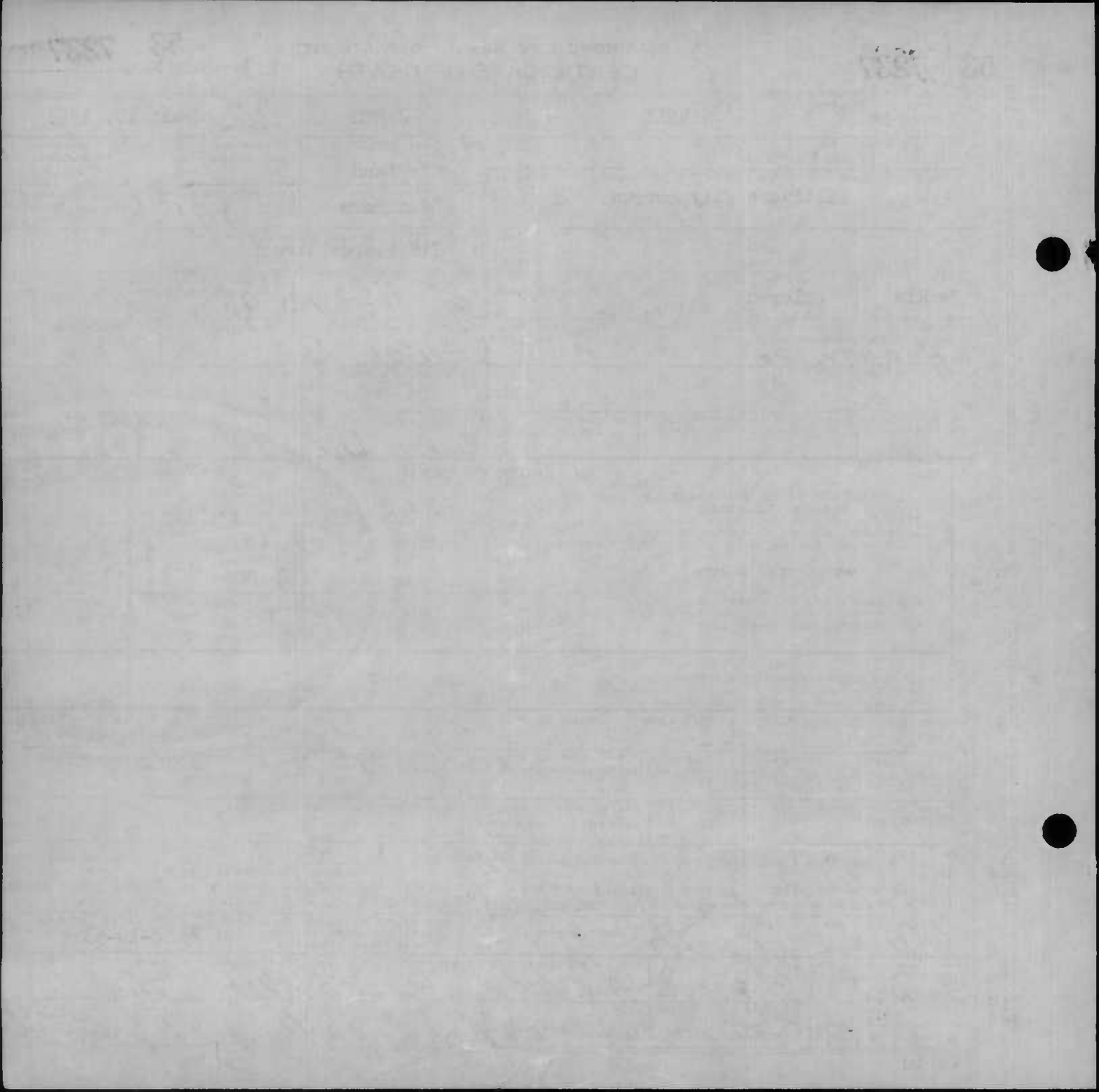
53 7237  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WINNIE</b>		2. DATE OF DEATH <b>August 10, 1953</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF (not in hospital or institution, give street address or location) <b>Baltimore City Morgue</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>715 Pierce Street</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>6/1/1857</b>
9. AGE (In years last birthday) <b>96</b>		10. UNDER 1 Year Months: _____ Days: _____	11. UNDER 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Aiken S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Carrie Dixon</b>		ADDRESS	

18. <b>422.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO		
ANTECEDENT CAUSES (B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>8/13/1953</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <b>inspection &amp; inquiry</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <b>natural causes</b> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>W. H. Williams</b>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>8-10-53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/13/1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>W. H. Williams Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		24E. NAME OF CEMETERY OR CREMATORY <b>W. H. Williams Cem.</b>		24F. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
24G. DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 12 1953</b>		24H. REGISTRAR'S SIGNATURE <b>Huntington Williams</b>		24I. FUNERAL DIRECTOR <b>W. H. Williams</b>	
24J. ADDRESS <b>8229</b>		24K. ADDRESS <b>8229</b>		24L. ADDRESS <b>8229</b>	



M-242

53 7238

53 7238

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Joseph M<sup>o</sup> Allister Jr.</i>		2. DATE OF DEATH <i>Aug. 8, 1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>17-01</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>629 Pierce St.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Ba/10.</i>	
C. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <i>629 Pierce St.</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Oct. 10, 1899</i>
9. AGE (In years, last birthday) <i>53</i>		10. UNDER 1 Year Months: _____ Days: _____	11. UNDER 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Florence S. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wm M<sup>o</sup> Allister</i>		14. MOTHER'S MAIDEN NAME <i>Corrine Brooks</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <i>Hubert M<sup>o</sup> Allister</i>		ADDRESS <i>629 Pierce St.</i>	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) (A) <i>MYO CARDIAL FAILURE</i> DUE TO <i>1 DAY</i>			
ANTECEDENT CAUSES (B) <i>HYPERTENSIVE CARDIO-VASCULAR DISEASE</i> DUE TO <i>6 YRS</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>JUNE</i> , 1947, to <i>Aug 8</i> , 1953, that I last saw the deceased alive on <i>8-8</i> , 1953, and that death occurred at <i>2:45 P.m.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>Thomas W. Harris</i>		23B. ADDRESS <i>1824 W. Franklin St</i>	
23C. DATE SIGNED <i>8-11-53</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/12/1953</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Wm M<sup>o</sup> Allister Jr. Am Ballo.</i>		24D. LOCATION (City, town, or county) (State) <i>MD.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 12 1953</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i>	
FUNERAL DIRECTOR <i>Wm M<sup>o</sup> Williams</i>		ADDRESS <i>9228</i>	

VS 150

97099

MEDICAL CERTIFICATION





D-534  
53 7239

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7239

1. NAME OF DECEASED (Type or Print) <b>Antonio Donatelli</b>		2. DATE OF DEATH <b>August 10 53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>3701 Echodale Ave</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore <b>67 Yrs.</b>		D. STREET ADDRESS (If rural, give location) <b>3701 Echodale Ave</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>January 17 1870 (85)</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mens Coats Presser</b>		11. BIRTHPLACE (State or foreign country) <b>Ateleta Aquila Italy</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>(Tailor Shop)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Donato Donatelli</b>		14. MOTHER'S MAIDEN NAME <b>Carminella Sciullo</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-24-8125</b>	
17. INFORMANT <b>Ralph Donatelli</b>		ADDRESS <b>3701 Echodale Ave</b>	
18. <b>490X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Lobar pneumonia, left</b>		CAUSE OF DEATH (A) <b>Lobar pneumonia, left</b> DUE TO (B) DUE TO (C)	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>1) Bleeding gastric ulcer</b> <b>2) arteriosclerotic cardio-vascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Feb</b> , 19 <b>53</b> , to <b>Aug 10</b> , 19 <b>53</b> that I last saw the deceased alive on <b>Aug 10</b> , 19 <b>53</b> , and that death occurred at <b>9:45 AM</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Charles M. Carr</b>		23B. ADDRESS <b>6801 Belair Rd. #6</b>	
23C. DATE SIGNED <b>Aug 11, 53</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 13 1953</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>4430 Belair Rd.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 12 1953</b>		REGISTRAR'S SIGNATURE <b>Thurston Wallace</b>	
FUNERAL DIRECTOR <b>Edw. Della Noe</b>		ADDRESS <b>322 S. High S</b>	

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RECEIVED THE SECRETARY OF THE  
NAVY DEPARTMENT

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OFFICE OF THE SECRETARY OF THE NAVY

WASHINGTON, D. C.

NOV 10 1910

TO THE SECRETARY OF THE NAVY

FROM THE SECRETARY OF THE NAVY

RECEIVED THE SECRETARY OF THE NAVY

NOV 10 1910

NOV 10 1910

RECEIVED THE SECRETARY OF THE NAVY  
NOV 10 1910  
OFFICE OF THE SECRETARY OF THE NAVY  
WASHINGTON, D. C.

RECEIVED THE SECRETARY OF THE NAVY  
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OFFICE OF THE SECRETARY OF THE NAVY  
WASHINGTON, D. C.

RECEIVED THE SECRETARY OF THE NAVY

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RECEIVED THE SECRETARY OF THE NAVY

NOV 10 1910

5-530  
53 7240

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7240

1. NAME OF DECEASED (Type or Print) <i>Eora M. Smith</i>		2. DATE OF DEATH <i>Aug 12, 1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived in institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY	
5. FULL NAME OF (If not in hospital or institution, give street address or location) <i>5721 Nasco Place</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 27-38</i>	
6. Length of stay in Baltimore X <i>Female</i> 6. COLOR OR RACE <i>White</i> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i> 8. DATE OF BIRTH <i>July 21-1917</i> 9. AGE (in years last birthday) <i>36</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i> 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Henry Grauling</i>		14. MOTHER'S MAIDEN NAME <i>Irene Manner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Leroy D. Smith</i> ADDRESS <i>5721 Nasco Place</i>		18. <i>171X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	
19. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>	
(A) <i>Carcinoma of Cervix</i>			
DUE TO			
(B) <i>Generalized Metastasis</i>			
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
I hereby certify that I attended the deceased from <i>Feb</i> , 19 <i>53</i> to <i>Aug</i> , 19 <i>53</i> that I last saw the deceased alive on <i>Aug 7</i> , 19 <i>53</i> and that death occurred at <i>m.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>Chas B. Macek</i>		23B. ADDRESS <i>605 Medical Arts</i>	
23C. DATE SIGNED <i>Aug 13, 1953</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Aug. 14-1953</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Balto. National</i>		24D. LOCATION (City, town, or (State) <i>Balto. Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 12 1953</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>	
25. FUNERAL DIRECTOR <i>John W. Miller</i>		ADDRESS <i>12334 Jefferson St.</i>	

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

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James M. Jones

James M. Jones  
James M. Jones

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53

E-165  
7241BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

X Registered No. 53 7241

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Ever weine, Rae.

2. DATE  
OF  
DEATH

8/10/53.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland.

Kent.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

University Hospital.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Millington.

D. STREET ADDRESS (If rural, give location)

6400

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F.

6. COLOR OR RACE

W.

7. SINGLE, ~~MARRIED~~  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

June 18

9. AGE (In years  
last birthday)

45

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Maryland.

12. CITIZEN OF  
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

husband.

ADDRESS

Same.

18. 331X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Cerebro vascular accident.

8 days.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Hypertension of.

about 1 yr.

(C) DUE TO

unknown etiology.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

8/10/53

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED exploratory for  
increase intracranial pressureIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-7-1953 to 8-10-1953, that I last saw the  
deceased alive on 8-11-1953, and that death occurred at 3:30 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Joseph R. Bove

23B. ADDRESS

University Hospital

23C. DATE SIGNED

8/11/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 14, 1953

24C. NAME OF CEMETERY OR CREMATORY

Millington Cemetery

24D. LOCATION (City, town, or county)

Millington

(State)

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

AUG 12 1953

REGISTRAR'S SIGNATURE

Huntington Williams, Jr.

25. FUNERAL DIRECTOR

Edward Fillmore Millington, Md.

ADDRESS

1950 12

1950 12

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ALICE V.  
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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **53 7242**

BIRTH NO. <b>E162</b> <b>7242</b>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. <b>53 7242</b>	
1. NAME OF DECEASED (Type or Print) <b>ALBERT H. EVERSMIER (EVERSMIER)</b>			2. DATE OF DEATH <b>August 10, 1953</b>		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence) a. STATE <b>Maryland</b> b. COUNTY <b>before admission</b>		
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hosp.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore <b>LIFE</b> Yrs. Mos. Days			d. STREET ADDRESS (If rural, give location) <b>352 S. Elrino Street</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>JAN. 29, 1889.</b>	9. AGE (in years last birthday) <b>64</b>	10. Under 1 Year Months: Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRODUCE DEALER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>SELF.</b>		
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>HENRY EVERSMIER</b>			14. MOTHER'S MAIDEN NAME <b>ELIZABETH ?</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NO</b>		
17. INFORMANT <b>KATHERINE E. EVERSMIER</b>			ADDRESS <b>SAME</b>		
18. <b>422.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) (C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <u>inspection &amp; inquiry</u> thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23a. SIGNATURE <b>Joseph A. Jackson, Jr.</b>		23b. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23c. DATE SIGNED <b>Aug. 11, 1953</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>8-13-1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEM.</b>	
24d. LOCATION (City, town, or county) (State) <b>7401 GERMAN HILL RD. MD.</b>		25. FUNERAL DIRECTOR <b>Charles S. Geiler</b> ADDRESS <b>901 S. CONKLING ST. BALTO., MD.</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 12 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>			
VS 151 <b>2906A</b>					

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7248

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7248

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>THEODORE</b>			2. DATE OF DEATH <b>August 12, 1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Josephs Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
6. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>1404 East Oliver Street</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	B. DATE OF BIRTH <b>Aug 29, 1943</b>	9. AGE (In years last birthday) <b>9</b>	If Under 1 Year Months Days If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>BALTO., Md</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>JOHN BARNES</b>			14. MOTHER'S MAIDEN NAME <b>HELENE JENNINGS</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>HELENE BARNES 1404 E. OLIVER ST</b>		

18. E 813.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Multiple skull fractures</b>		CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DUE TO		(A)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Cerebral edema</b>		(B)	
DUE TO		(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>on street</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>in front of 1400 N. Caroline Street</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>8/12/53 9:30</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>while riding scooter was struck by truck</b>	
22. I certify that I took charge of the remains described above, held an <b>Autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>Joseph A. Jackimezyk</b>		23B. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER MEDICAL INVESTIGATOR		23C. DATE SIGNED <b>8/12/53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-14-53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>ARbutus MEM. PK</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>		24E. FUNERAL DIRECTOR <b>Joseph S. Locke</b>		24F. ADDRESS <b>1304 N. Central</b>	

8457

23

8457

23

W-436  
53 7244BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7244

1. NAME OF DECEASED (Type or Print) <b>MR. CARL JOHN WALTER</b>		2. DATE OF DEATH <b>8/12/53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>PHOENIX</b>	
D. STREET ADDRESS (If rural, give location) <b>STOCKTON ROAD 5200</b>		5. LENGTH OF stay in Baltimore Yrs. Mos. Days	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>W</b>	8. DATE OF BIRTH <b>JULY 10 1882</b>
9. AGE (In years last birthday) <b>71</b>		10. Under 1 Year Months: Days	
11. Under 24 Hours Hours: Min.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brewer</b>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Frederick Walter</b>	
14. MOTHER'S MAIDEN NAME <b>Augusta (unknown)</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>313-052743A</b>		17. INFORMANT <b>Mrs. John Alban</b>	
ADDRESS <b>Same</b>		18. <b>421A</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Aortic insufficiency</b> DUE TO (A) <b>Aortic insufficiency</b> (B) (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Obstructing lesion of cardia of stomach</b>	
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <b>Aug 8</b> 19 <b>53</b> , to <b>Aug 12</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>Aug 12</b> , 19 <b>53</b> and that death occurred at <b>9:25</b> A.m., from the causes and on the date stated above.	
23A. SIGNATURE <b>Hugh M. Brown</b>		23B. ADDRESS <b>U M H</b>	
23C. DATE SIGNED <b>8/12/53</b>		24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>8-15-53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. John's Lutheran</b>	
24D. LOCATION (City, town, or county) (State) <b>Sweet Air, Md</b>		24E. DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 12 1953</b>	
24F. REGISTRAR'S SIGNATURE <b>Huntington</b>		24G. FUNERAL DIRECTOR <b>W. L. 7. 2001 Brooks, Sparks, Md.</b>	
24H. ADDRESS <b>594 46</b>			

MEDICAL CERTIFICATION

1955

20

DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

1955

1955



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-600  
53 7245BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7245  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES

LARRY

MOORE

2. DATE OF DEATH  
July 13, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION  
If not in hospital or institution, give street address or location)  
Baltimore City Morgue4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

Found: Rear of 2510 Loch Raven Road

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

U

9. AGE (In years last birthday)

60

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

N

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

K

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

N

14. MOTHER'S MAIDEN NAME

O

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

W

16. SOCIAL SECURITY NO.

17. INFORMANT

N

ADDRESS

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)(A) Obliterative Coronary Sclerosis with  
xxxx Former Myocardial Infarction

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) .....  
DUE TO  
(C) .....II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

ml. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

R. B. Fisher

23B. CHIEF MEDICAL EXAMINER.....☒ ASSISTANT MEDICAL EXAMINER.....☐ MEDICAL INVESTIGATOR.....☐23C. DATE SIGNED  
7-13-53

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

UNIVERSITY MEDICAL SCHOOL AUG 11 1953

Huntington Williams, M.D.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-620  
53 7246BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7246  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary A. Braugh

2. DATE  
OF  
DEATH

Aug. 11, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or  
location)

2613 Hilton St.

C. CITY OR TOWN (If outside corporation limits, write RURAL and give  
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2613 Hilton St.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Sept. 3, 1881

9. AGE (In years  
last birthday)

71

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR  
INDUSTRY

--

11. BIRTHPLACE (State or foreign country)

England

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James J. Lawless

14. MOTHER'S MAIDEN NAME

Mary A. Cunningham

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

ADDRESS

M. Catherine McGuirk 2613 Hilton St.

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardio-  
Vascular Disease with

ANTECEDENT CAUSES

(B) Hypertension

8 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-1, 1953, to 8-11, 1953, that I last saw the  
deceased alive on 8-10, 1953, and that death occurred at 5:30 a. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8-13-1953

24C. NAME OF CEMETERY OR CREMATORY

Mt. Olivet

24D. LOCATION (City, town, or county)

Washington,

D. C.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 13 1953

Huntington Halligan, M.D.

G. Howard Strong 3207 W. North Ave.,

Dr. Philip H. Ely  
11 E. Chase St.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. **53 7247**

**1. NAME OF DECEASED** (Type or Print) **SARAH D. JOHNSON**

**2. DATE OF DEATH** **Aug. 11, 1953**

**3. PLACE OF DEATH:**  
**A. Baltimore City, Maryland Balto. City**  
**B. FULL NAME OF HOSPITAL OR INSTITUTION** **Johns Hopkins Hospital**  
**C. Length of stay in Baltimore** **Life**  
**5. SEX** **Female** **6. COLOR OR RACE** **Colored** **7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)** **Single**  
**10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)** **None** **10B. KIND OF BUSINESS OR INDUSTRY** **None**  
**13. FATHER'S NAME** **Otto Johnson**  
**15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)** **No** **16. SOCIAL SECURITY NO.**  
**4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)**  
**A. STATE** **Maryland** **B. COUNTY**  
**C. CITY OR TOWN** **Baltimore** **D. STREET ADDRESS (If rural, give location)** **1424 Hempel Court**  
**9. AGE (In years last birthday)** **10-0-0** **11. BIRTHPLACE (State or foreign country)** **Baltimore** **12. CITIZEN OF WHAT COUNTRY?** **U.S.A.**  
**14. MOTHER'S MAIDEN NAME** **Viola Johnson**  
**17. INFORMANT** **Viola Johnson** **ADDRESS** **1424 Hempel Ct.**

**18. 340.3 CAUSE OF DEATH**  
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
**(A) Acute meningitis**  
**ANTECEDENT CAUSES**  
**(B) Bronchopneumonia**  
**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.**  
**(C)**  
**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.**

**19A. DATE OF OPERATION** **19B. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** **YES** ☒ **NO** ☐

**21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.** **21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)** **21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)**  
**21D. TIME (Month) (Day) (Year) (Hour) OF INJURY** **21E. INJURY OCCURRED** **21F. HOW DID INJURY OCCUR?**  
**WHILE AT WORK** ☐ **NOT WHILE AT WORK** ☐

**22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.**

**23A. SIGNATURE** **Joseph A. Jachimczyk M.D.** **23B. CHIEF MEDICAL EXAMINER** ☐ **23C. DATE SIGNED** **Aug. 11, 1953**  
**ASSISTANT MEDICAL EXAMINER** ☒ **MEDICAL INVESTIGATOR** ☐

**24A. BURIAL, CREMATION, REMOVAL (Specify)** **Burial** **24B. DATE** **8/13/1953** **24C. NAME OF CEMETERY OR CREMATORY** **Mt Calvary Cem.** **24D. LOCATION (City, town, or county) (State)** **Baltimore**

**DATE RECEIVED BY LOCAL REGISTRAR** **AUG 13 1953** **REGISTRAR'S SIGNATURE** **Huntington** **25. FUNERAL DIRECTOR** **Wilson** **ADDRESS** **Wilson**

1917

82

1917

82



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. **53 7248**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

**Ben Smith**

2. DATE OF DEATH **Aug. 11, 1953**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

**Pennsylvania**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

**US PHS Hospital  
Baltimore 11, Maryland**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**Erie**

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

**508 West 4th Street**

5. SEX

**Male**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**Single**

8. DATE OF BIRTH

**Feb. 14, 1885**

9. AGE (In years, last birthday)

**68**

11 Under 1 Year Months Days

11 Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Seaman**

10B. KIND OF BUSINESS OR INDUSTRY

**Seafaring**

11. BIRTHPLACE (State or foreign country)

**Poland**

12. CITIZEN OF WHAT COUNTRY?

**USA**

13. FATHER'S NAME

**Joseph Smith**

14. MOTHER'S MAIDEN NAME

**Mary ?**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

**No**

16. SOCIAL SECURITY NO.

**177-16-3210**

17. INFORMANT

ADDRESS

**Records, US PHS Hospital, Balto 11, Md.**

18. **141X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

**Metastatic squamous cell carcinoma of left internal jugular chain of lymph nodes.**

**10 months**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

**Squamous cell carcinoma Grade 2 of tongue and floor of mouth**

**10 months**

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **5-29-**, 19**53**, to **8-11-53**, 19**53**, that I last saw the deceased alive on **8-11-53**, and that death occurred at **10:50 a.m.**, from the causes and on the date stated above.

23A. SIGNATURE **James A. Hunter**  
**James A. Hunter, Med. Director M. D.**

23B. ADDRESS

**US PHS Hospital, Balto., Md.**

23C. DATE SIGNED

**8-12-53**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Removal**

24B. DATE

**8/12/53**

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

**Erie, Penn.**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

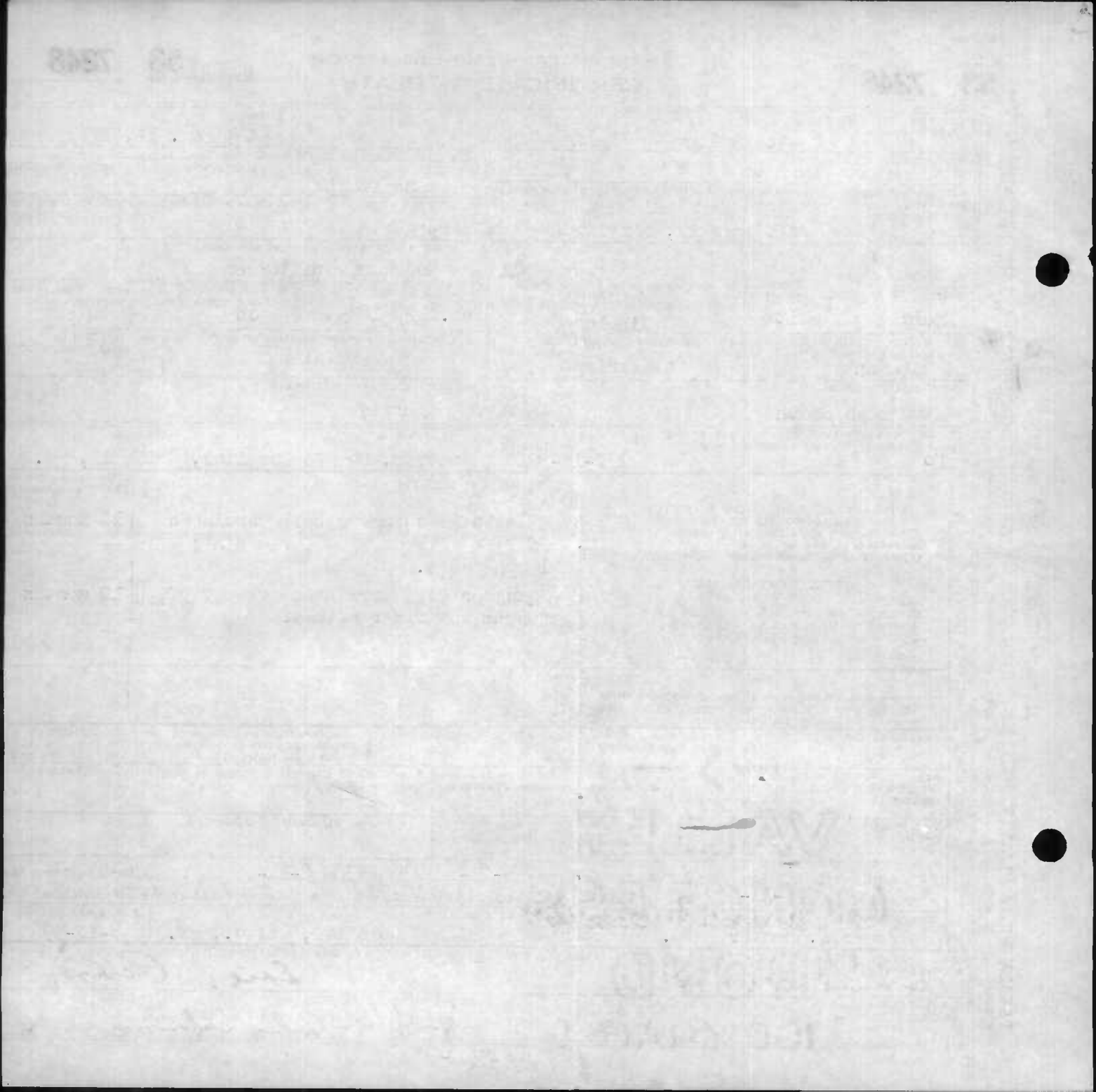
25. FUNERAL DIRECTOR

ADDRESS

**AUG 12 1953**  
VS 150

**673 55**

**George A. Farley Cantonville, Md.**



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **53 7249**

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>EARL W. BELCHER</b>		2. DATE OF DEATH <b>8-9-53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>CITY MORGUE</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>722 N. Broadway</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>1-13-1920</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construct. Worker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	9. AGE (In years last birthday) <b>33</b>
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Daniel</b>		14. MOTHER'S MAIDEN NAME <b>Mattie Davidson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>?</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Dahz Austell Fun. Home, Shelby N.C.</b>		ADDRESS	

18. <b>E 9-9-81</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>DROWNING</b> (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES (B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION <b>8-12-53</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB. <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>harbor</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Between Piers 3 &amp; 4-Pratt St. 4/1</b>	
21D. TIME (Month) (Day) (Year) (Hour) of INJURY <b>Aug. 9, 1953 early A. m.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Seen to fall overboard into water</b>	
22. I certify that I took charge of the remains described above, held an <b>INSPECTION + INQUIRY</b> and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>Joseph A. Jachimecz</b>		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <b>8-9-53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>8-12-53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Zoar Baptist Ch. Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Shelby North Carolina</b>		25. FUNERAL DIRECTOR <b>Deane S. Farley</b>		ADDRESS <b>Catonville Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 12 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington</b>		25. FUNERAL DIRECTOR <b>Deane S. Farley</b>	

1957

22

1957

22

EARL W. BELL

EX-100-100

G-230

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7250  
Registered No. 53 7250

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Conrad Max Gast

2. DATE  
OF  
DEATH

Aug 12, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

3605 6th. St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

2525-04

D. STREET ADDRESS (If rural, give location)

3605 6th St.

Length of stay in Baltimore

70 Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

Nov 22, 1974

9. AGE (In years  
last birthday)

78

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Blacksmith

10B. KIND OF BUSINESS OR  
INDUSTRY

Metal - MFG.

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

John. GAST

14. MOTHER'S MAIDEN NAME

Amelia

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

213-120518

17. INFORMANT

Son - Edgar C Gast

ADDRESS

539 Amabelly

18. 157X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Heart failure  
DUE TO Cachexia, advanced

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Carcinoma Pancreas,  
DUE TO metastatic

(C)

INTERVAL BETWEEN  
ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Dec 10, 1952

19B. MAJOR FINDINGS OF OPERATION

Unresectable Cancer - Pancreas

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 12, 1952 to Aug 12, 1953, that I last saw the  
deceased alive on Aug 11, 1953, and that death occurred at 9:50 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Harry Cole

M. D.

23B. ADDRESS

803 Cittermo St

23C. DATE SIGNED

Aug 12, 1953

24A. BURIAL, CREA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Dec 15, 1953

24C. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cem.

24D. LOCATION (City, town, or county)

Anne Arundel Co, Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

George J. Gorce 4601 Ritchie

ADDRESS

Newy

VS 150

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

478

1901

1. Name of deceased *John Doe*  
2. Sex *Male*  
3. Age *45*  
4. Date of death *Jan 15 1901*  
5. Place of death *Home*  
6. Cause of death *Heart Disease*  
7. Signature of physician *J. H. Smith*  
8. Signature of registrar *W. B. Jones*

STATE OF NEW YORK

9. Name of informant *John Doe*  
10. Address of informant *123 Main St, New York City*  
11. Signature of informant *J. Doe*  
12. Date of filing *Jan 16 1901*  
13. Registrar's Office *New York City*  
14. Signature of Registrar *W. B. Jones*  
15. Date of filing *Jan 16 1901*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7251

BIRTH NO.

ROSA DANDY  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7251

1. NAME OF DECEASED (Type or Print) <b>DANDY ROSA</b>			2. DATE OF DEATH <b>8-10-53</b>		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <b>md.</b> b. COUNTY <b>Balto</b>		
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto</b>		
c. Length of stay in Baltimore			d. STREET ADDRESS (If rural, give location) <b>3808 Elm Ave</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>N</b>	7. SINGLE, <u>MARRIED</u> , WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>Feb 19 1884</b>		9. AGE (In years last birthday) <b>69</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>WM I. McCULLOUGH.</b>			14. MOTHER'S MAIDEN NAME <b>RACHAEL HAYES Mc Cullough</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>HOWARD F. DANDY - 3808 ELM AVE</b>		
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			CAUSE OF DEATH (A) <b>Myocardial infarction massive</b> DUE TO (B) <b>Hypertensive Cardio-vascular Heart disease</b> DUE TO (C)		
INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7-29</b> , 19 <b>53</b> to <b>8-10</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>8-10</b> , 19 <b>53</b> and that death occurred at <b>7:50 Pm.</b> , from the causes and on the date stated above.					
23a. SIGNATURE <b>D. Felipe Gonzaly</b>		23b. ADDRESS <b>University Hospital</b>		23c. DATE SIGNED <b>7-10-53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Aug 14/53</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Pine Grove</b>	
24d. LOCATION (City, town, or county) (State) <b>Balto Co, Md.</b>		25. FUNERAL DIRECTOR <b>Funerary Williams, McChristian &amp; Donovan</b>		ADDRESS <b>3815 Roland Ave.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 13 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>		25. FUNERAL DIRECTOR ADDRESS <b>3815 Roland Ave.</b>	



F-120

53 7252

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7252

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Charles Fabig

2. DATE  
OF  
DEATH

8/11/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

South Balto. General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 25-06

D. STREET ADDRESS (If rural, give location)

3733 Leo St.

Length of stay in Baltimore

Yrs.  
Mos.  
Days

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

2/21/1876

9. AGE (in years  
last birthday)

77

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

MAINTENANCE

10B. KIND OF BUSINESS OR  
INDUSTRY

Box Mfg. Co.

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Frederick FABIG.

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

MR. ALBERT FABIG. 3733 LEO ST.

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Coronary Embolism

Immediate

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO  
(C)II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.Cholecystitis, acute  
Atelectasis, right base

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 28, 1953, to Aug. 11, 1953, that I last saw the  
deceased alive on Aug. 11, 1953 and that death occurred at 7:50 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Doyle Benno J. M. D.

1213 Light St

8/11/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL

8/14/53

MEADOWRIDGE

WASHINGTON BLVD.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 13 1953

Huntington Williams, M.D.

JOHN F. DENNY, INC. 715 LIGHT ST.

VS 150

MEDICAL CERTIFICATION

1957

RECEIVED

1957



88-500  
53 7253

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7253

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>MARY C. RYAN</i>		2. DATE OF DEATH <i>AUG-10-1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>859 PARK AVE</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>BALTIMORE 11-02</i>			
D. STREET ADDRESS (If rural, give location) <i>859 PARK AVE</i>		E. LENGTH OF STAY IN BALTIMORE <i>10</i> Yrs. <del>Mos.</del> <del>Days</del>			
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>JAN 7-1861</i>	9. AGE (In years, last birthday) <i>92</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Neg NURSE Net</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>NEW PORT P.S.</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>MARTIN BOYLE</i>		14. MOTHER'S MAIDEN NAME <i>DELIA CONLON</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT ADDRESS <i>LAURENCE A. RYAN 859 PARK AVE</i>	
18. <i>442X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Anterograde Cardiac Vascular</i> DUE TO <i>Renal Disease (old age)</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>?</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>5/30</i> , 19 <i>53</i> , to <i>8/6</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>8/6</i> , 19 <i>53</i> , and that death occurred at <i>9:30 P.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>James L. Blum M.D.</i>		23B. ADDRESS <i>1115 N. Calver St.</i>		23C. DATE SIGNED <i>8/10/53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>AUG 14, 1953</i>		24C. NAME OF CEMETERY OR CREMATORY <i>ST FRANCIS CEM</i>	
24D. LOCATION (City, town, or county) <i>PAWTUCKETT R. ISLAND</i>		24E. NAME OF FUNERAL DIRECTOR <i>PRATT &amp; STRICKER STS</i>		24F. ADDRESS <i>PRATT &amp; STRICKER STS</i>	

MEDICAL CERTIFICATION

DATE RECEIVED BY LOCAL REGISTRAR  
AUG 13 1953  
VS 150





N-520

53 7254

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7254

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JOSEPH FRANK NEMEC</b>		2. DATE OF DEATH <b>August 11, 1953</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland 803 N. Lakewood Ave.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 7-02</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION		D. STREET ADDRESS (If rural, give location) <b>803 N. Lakewood Avenue</b>		E. LENGTH OF STAY IN BALTIMORE <b>life</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>divorced</b>	8. DATE OF BIRTH <b>Nov. 10, 1896</b>	9. AGE (In years last birthday) <b>56</b>	10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Police Force</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph F. Nemec</b>		14. MOTHER'S MAIDEN NAME <b>Mary Kubin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W. #1</b>		17. INFORMANT ADDRESS <b>Charles Nemec, 2538 Ashland Avenue</b>	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma Oesophagus (lower end)</b> DUE TO (A) <b>6 mos</b> (B) (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH <b>Carcinoma Oesophagus (lower end)</b> DUE TO (A) (B) (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Feb. 4, 1953</b> to <b>Aug. 11, 1953</b> , that I last saw the deceased alive on <b>Aug. 9, 1953</b> , and that death occurred at <b>9:30 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Joseph P. Pokorny</b>		23B. ADDRESS <b>2200 E. Madison St.</b>		23C. DATE SIGNED <b>8/12/53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 14, 1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		24E. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		24F. LOCATION (City, town, or county) <b>Baltimore, Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 13 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>		25. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>	
25. FUNERAL DIRECTOR <b>2601-3-5 E. Madison St.</b>		25. FUNERAL DIRECTOR <b>2601-3-5 E. Madison St.</b>		25. FUNERAL DIRECTOR <b>2601-3-5 E. Madison St.</b>	

1961

12

BARTMORE CIVIL HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

1961

JANUARY 11, 1961

DECEASED

JANUARY 11, 1961

JANUARY 11, 1961

JANUARY 11, 1961

JANUARY 11, 1961

JANUARY 11, 1961

JANUARY 11, 1961

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JANUARY 11, 1961

JANUARY 11, 1961

J-520

53 7255

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7255  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>John WILLIAM JONES</b>		2. DATE OF DEATH <b>8/11/53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Balto</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto</b> <b>8-03</b>	
D. STREET ADDRESS (If rural, give location) <b>1115 N. Lakewood Ave</b>		E. LENGTH OF stay in Baltimore Yrs. Mos. Days	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>1/18/1910</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>woodworker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>League Lumber Co.</b>	9. AGE (In years last birthday) <b>43</b>
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Jones</b>		14. MOTHER'S MAIDEN NAME <b>Anna E. Maurer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Anna Tuma Jones, wife, above</b>		ADDRESS	

18. **154X**

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

**coarctatic condition**

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

**Diffuse CARCINOMATOSIS of Bowel and Abdominal wall**

DUE TO

(C)

**original lesion of CARCINOMA IN RECTO-SIGMOID BOWEL**

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

**BRONCHOPNEUMONIA**

19A. DATE OF OPERATION <b>10/10/52</b>		19B. MAJOR FINDINGS OF OPERATION <b>TUMOR RECTO-SIGMOID-METASTASIS to 1. BLADDER 2. LIVER</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7/4/53</b> , 19 <b>53</b> , to <b>8/11/53</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>8/11</b> , 19 <b>53</b> , and that death occurred at <b>5:30 P.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Robert S. Cowlan</b>		23B. ADDRESS <b>Sinai Hospital</b>		23C. DATE SIGNED <b>8/12/53</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 14, 1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>Aug 13 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>		25. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>2607-35 E. Madison St.</b>	

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MEDICAL CERTIFICATION

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAP-137064

BIRTH NO.

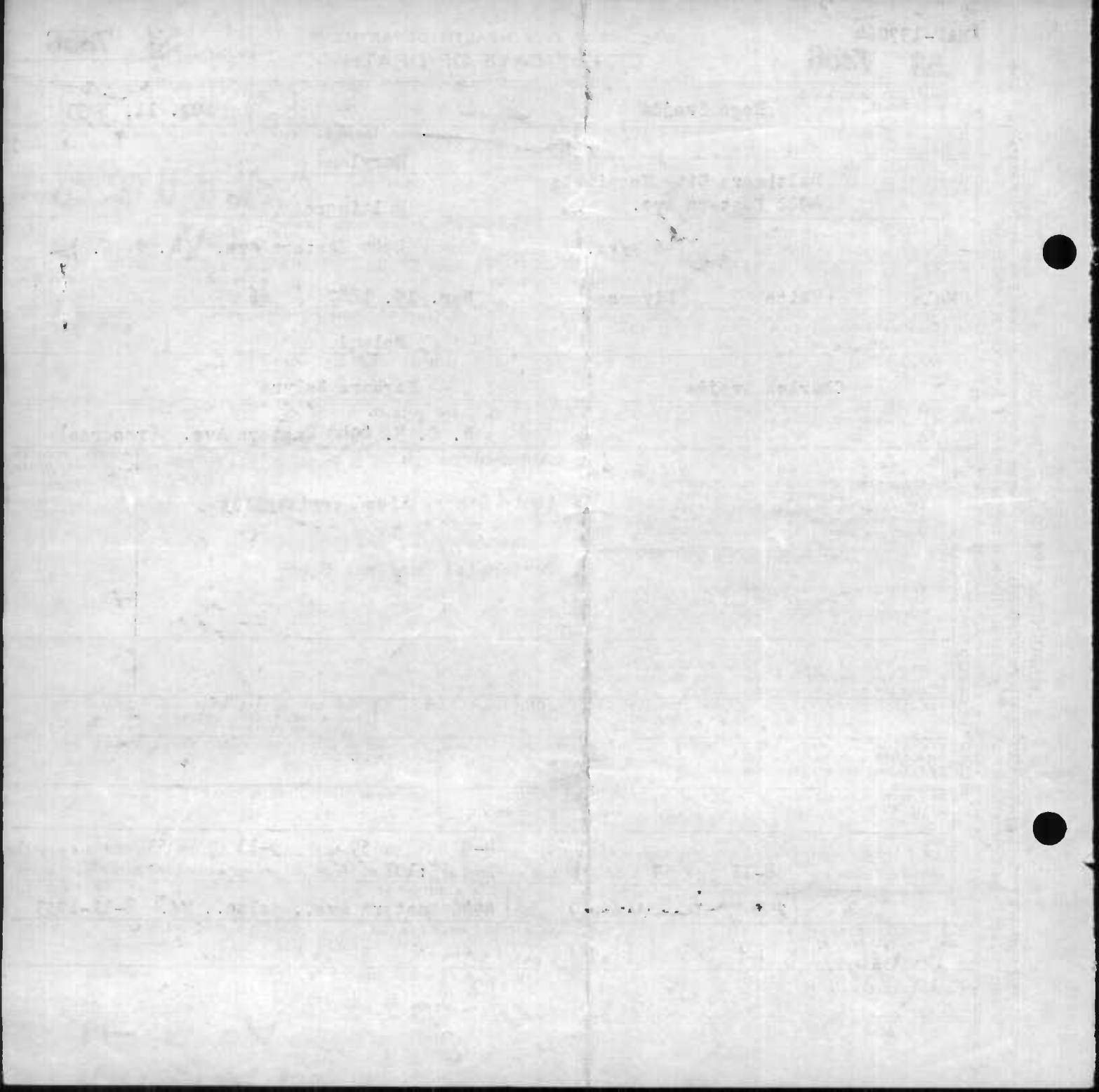
# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

53 7256

1. NAME OF DECEASED (Type or Print) <b>Bego Svojda</b>		2. DATE OF DEATH <b>Aug. 11, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
5. Length of stay in Baltimore <b>46 yrs.</b>		D. STREET ADDRESS (If rural, give location) <b>4940 Eastern Ave. (B. C. H.)</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>Mar. 19, 1887</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Jeweler</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years, last birthday) <b>66</b>
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Charles Svejda</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Sekyra</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>B. C. H.</b>		ADDRESS <b>4940 Eastern Ave. (records)</b>	
18. <b>541.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Generalized Peritonitis</b> DUE TO <b>Perforated Duodenal Ulcer</b> DUE TO <b>Perforated Duodenal Ulcer</b> DUE TO			INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>7</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <b>4-4</b> , 19 <b>50</b> , to <b>8-11</b> , 19 <b>53</b> that I last saw the deceased alive on <b>8-11</b> , 19 <b>53</b> , and that death occurred at <b>5:10 P. M.</b> , from the causes and on the date stated above.		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23A. SIGNATURE <b>Dr. John V. ...</b>		23B. ADDRESS <b>4940 Eastern Ave., Balto., Md.</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-14-53</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. - MD</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 13 1953</b>		REGISTRAR'S SIGNATURE <b>...</b>	
25. FUNERAL DIRECTOR <b>...</b>		ADDRESS <b>2716 E. Monument St.</b>	

29065





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7257

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

53 7257  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Mrs. Mildred Craig</i>		2. DATE OF DEATH <i>8-12-53</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore Md</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>St. Aganes Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
c. Length of stay in Baltimore <i>45 yrs</i>		D. STREET ADDRESS (If rural, give location) <i>417 Evesham Ave</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>1231X L 12-31-1907 45</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Aero Mfrs.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Glen L. Martin's</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S. A</i>	
13. FATHER'S NAME <i>Robert W Morris</i>		14. MOTHER'S MAIDEN NAME <i>Edna Burke</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-20-5518</i>	
17. INFORMANT <i>Sherlock L Craig</i>		ADDRESS <i>Same</i>	
18. <i>410X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Pulmonary edema</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Rheumatic heart disease</i>		(B) <i>intercalated stenosis is insuff.</i> <i>annular fibrosis</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Pneumonitis, left lower lobe</i>			
19A. DATE OF OPERATION <i>0</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>8-10</i> , 19 <i>53</i> , to <i>8-12</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>8-12</i> , 19 <i>53</i> , and that death occurred at <i>11:10 PM</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>Donald A. Waepel</i>		23B. ADDRESS <i>St. Agnes Hospital</i>	23C. DATE SIGNED <i>8-12-53</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Aug 15/53</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Moreland Memorial Park</i>	24D. LOCATION (City, town, or county) (State) <i>Balto. Md</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 13 1953</i>	REGISTRAR'S SIGNATURE <i>W. Williams</i>	25. FUNERAL DIRECTOR <i>W. Williams</i>	ADDRESS <i>4905 York</i>
VS 150 <i>6903T</i>			

TEST 8

10/10/10

STANDARD 10/10/10

TEST 8

VALLEY  
CONGRESS  
BOND  
10/10/10  
U.S.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

E-524

53 7258

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7258  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH T. ENGLAND

2. DATE  
OF  
DEATH

Aug. 12, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

228 W. LAFAYETTE AVE.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTO.

14-01

D. STREET ADDRESS (If rural, give location)

228 W. LAFAYETTE AVE.

C. Length of stay in Baltimore

LIFE

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

DIVORCED

8. DATE OF BIRTH

APRIL 29, 1883

9. AGE (in years

last birthday)

70

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LAWYER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CHARLES ENGLAND

14. MOTHER'S MAIDEN NAME

MARY E. SMITH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

214-18-6081

17. INFORMANT

C.W. MAGRUDER JAMESTOWN, R.I.

ADDRESS

18. 204.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Leukemia, myeloid, acute. 6 mo.

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cirrhosis of liver

5 yr.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT

WORK

NOT WHILE

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1951 to Aug. 12, 1953 that I last saw the deceased alive on Aug. 11, 1953, and that death occurred at 1:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

MR. Freeman R.

23B. ADDRESS

11 W. 29th ST.

23C. DATE SIGNED

Aug 13, 1953

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

8-14-1953

24C. NAME OF CEMETERY OR CREMATORY

DRUID RIDGE

24D. LOCATION (City, town, or county)

PIKESVILLE

MD

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 13 1953

Huntington Hills, Md. H. W. JENKINS &amp; SONS Co. 4905 YORK RD.

VS 150

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

L-230 CERTIFICATE CORRECTED 8-19-53				BALTIMORE CITY HEALTH DEPARTMENT		53 7259		Registered No. 53 7259	
BIRTH NO.				53 7259		BIRTH NO.		53 7259	
1. NAME OF DECEASED (Type or Print) CHARLES TATE LEIGHT				2. DATE OF DEATH		12, AUG. 11, 1953			
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland		B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		Baltimore		27-09	
c. Length of stay in Baltimore				D. STREET ADDRESS (If rural, give location)		1504 Northwick Road			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married Widowed	8. DATE OF BIRTH Aug. 15, 1880		9. AGE (in years last birthday) 72	If Under 1 Year Months: Days		If Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auditor				10B. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Leight				14. MOTHER'S MAIDEN NAME Susan Lutton		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 705-10-4531	
17. INFORMANT Mrs. Catherine Flayhart				ADDRESS Above		18. 331X CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) Recent intracerebral hemorrhage		DOE TO			
ANTECEDENT CAUSES				(B) Subdural hematoma, right		DOE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(C) Recent Bilateral trephines		DOE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(D) Hypertensive cardiovascular disease		DOE TO			
19A. DATE OF OPERATION				19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .									
23A. SIGNATURE Joseph G. Jackman				23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR		23C. DATE SIGNED 8/12/53			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/53		24C. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		24D. LOCATION (City, town, or county) Baltimore, Md. (State)			
DATE RECEIVED BY LOCAL REGISTRAR AUG 13 1953		REGISTRAR'S SIGNATURE Huntington W. ...		25. FUNERAL DIRECTOR Wm J. Tickner, Inc.		ADDRESS Balto Md			

8557, 86

8557, 86



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7260

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7260

1. NAME OF DECEASED (Type or Print) <i>James Wallace</i>		2. DATE OF DEATH <i>Aug 11, 53</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Celiv 2</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Ind -</i> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore - 13-03</i>	
5. Length of stay in Baltimore <i>Life</i> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>1502 Whitelock St</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>SP</i>	8. DATE OF BIRTH <i>9--08</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur</i>		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <i>Frank Wallace</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Reed</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>		ADDRESS	

18. <i>260x</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral Thrombosis</i>	CAUSE OF DEATH (A) DUE TO	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Cerebral Arteriosclerosis</i>	(B) DUE TO <i>Diabetes Mellitus</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>0</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <i>Aug 10, 1953</i> to <i>Aug 11, 1953</i> that I last saw the deceased alive on <i>Aug 11, 1953</i> and that death occurred at <i>2:30 p.m.</i> from the causes and on the date stated above.			
23A. SIGNATURE <i>W Gordon Walker</i>	M. D.	23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>	23C. DATE SIGNED <i>12 Aug 53</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>8/15/53</i>	24C. NAME OF CEMETERY OR CREMATORY <i>St Thomas</i>	24D. LOCATION (City, town, or county) (State) <i>Randallstown, Md</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 13 1953</i>	REGISTRAR'S SIGNATURE <i>Huntington Williams</i>	25. FUNERAL DIRECTOR <i>6852 presstman St</i>	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C-520

53 7261

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7261

Registered No.

1. NAME OF DECEASED (Type or Print) <i>Minnie Lillian Gaines</i>		2. DATE OF DEATH <i>Aug. 11, 1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived in institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>1522 M<sup>e</sup> Culloh St.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 14-02</i>	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>1522 M<sup>e</sup> Culloh St.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>July 8, 1870</i>
9. AGE (In years last birthday) <i>83</i>		10. Under 1 Year Months: Days	
11. Under 24 Hours Hours: Min.		12. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Macon, Ga.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Janet Hill</i>		14. MOTHER'S MAIDEN NAME <i>Asiaiah Plant</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. DECEASED'S ADDRESS <i>1522 M<sup>e</sup> Culloh St.</i>		18. CAUSE OF DEATH	
18. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO		CARDIO-VASCULAR DISEASE <i>Coronary Artery Disease</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		Circulatory System <i>Coronary Artery Disease</i>	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Suprasterne pneumonia &amp; Scurvy</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 yrs.</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>August 10, 1953</i> , to <i>August 11, 1953</i> that I last saw the deceased alive on <i>Aug 10, 1953</i> , and that death occurred at <i>9:00 a.m.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>Robert H. Tinsley</i>		23B. ADDRESS <i>1325 N. Lamar St.</i>	
23C. DATE SIGNED <i>8/11/53</i>		24. LOCATION (City, town, or county) (State)	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Aug. 14, 1953</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Co. Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 13 1953</i>		REGISTRAR'S SIGNATURE <i>George H. Hill</i>	
MINERAL DIRECTOR <i>George H. Hill</i>		1631 <i>Orbit Hill Ave.</i>	

1957-58

1957-58

H-255-2010 Case Released				BALTIMORE CITY HEALTH DEPARTMENT		53 7262		Registered No. 53 7262	
BIRTH NO. 53 7262				A-500 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)				2. DATE OF DEATH				3. PLACE OF DEATH:	
Lillie M. Hawkins Queen				Aug 10, 1953				A. Baltimore City, Maryland	
B. FULL NAME OF (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. Institution: residence before admission)				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
JOHNS HOPKINS HOSPITAL				Md.				Baltimore 13-03	
c. Length of stay in Baltimore				D. STREET ADDRESS (If rural, give location)				1523 Clifton Ave	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		Colored		Widowed		May 52		52	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)	
								Baltimore Md.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?	
James H. Hawkins				Archie Smith				U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS	
								JOHNS HOPKINS HOSPITAL	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(A) Cerebral Vascular Accident				4 hrs.					
DUE TO									
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO					
				(C) Hypertensive cardiovascular disease					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				19C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8/10, 1953 to 8/10, 1953, that I last saw the deceased alive on 8/10, 1953 and that death occurred at 4:58 P.M., from the causes and on the date stated above.									
23A. SIGNATURE				23B. ADDRESS				23C. DATE SIGNED	
W. E. McArthur				JOHNS HOPKINS HOSPITAL				8/10/53	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		Aug-14-1953		Mt Calvary Cemetery		A. A. Co. Md			
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS			
AUG 13 1953		W. E. McArthur		W. E. McArthur		25-15th St. Elderly			



NOT A MEDICAL EXAMINER'S CASE

*Joseph G. Jackson*  
U.S.  
CHIEF OR ASST. MEDICAL EXAMINER



J-635  
53 7263BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7263

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MILLARD OLIVER JORDAN

2. DATE  
OF  
DEATH

August 12, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (not in hospital or institution, give street address or  
location)

South Baltimore General Hospital

C. CITY OR TOWN (If outside corporate limits, write (RURAL) and give  
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1318 Cambria Street

C. Length of stay in Baltimore

LIFE

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

October 3, 1916

9. AGE (In years  
last birthday)

36

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

PLASTIC MODEL MAKER

10B. KIND OF BUSINESS OR  
INDUSTRY

AIRCRAFT. MFG.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WALTER JORDAN

14. MOTHER'S MAIDEN NAME

EMMA GUDUTCH

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

NONE

16. SOCIAL  
SECURITY NO.

214-01-4843

17. INFORMANT

ADDRESS

IRENE JORDAN 1018 CAMBRIA ST

18. 470.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Coronary occlusion

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William J. Jordan

M.D.

23B. CHIEF MEDICAL EXAMINER..... ☐ASSISTANT MEDICAL EXAMINER..... ☒MEDICAL INVESTIGATOR..... ☐

23C. DATE SIGNED

August 13, 1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 17, 1953

24C. NAME OF CEMETERY OR CREMATORY

Cedar Hill

24D. LOCATION (City, town, or county)

Anne Arundel County Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

AUG 13 1953

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Geo. L. Schwab 2101 Frederick

ADDRESS

1887-88

THE UNIVERSITY OF CHICAGO  
LIBRARY

1887-88



D-400

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7264

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CHARLES <del>DATLEY</del> G. DAILY</b>			2. DATE OF DEATH <b>August 11, 1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Lutheran Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore City</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Lutheran Hospital</b> <b>430 Ashbluntown St. Baltimore Md.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>20-06</b>		
Length of stay in Baltimore <b>LIFE</b>			D. STREET ADDRESS (If rural, give location) <b>529 S. Caton Ave.</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>1907</b> <b>October 25, 1907</b>		9. AGE (In years last birthday) <b>51 1/2</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Bloede Chem.</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>GEORGE DAILY</b>			14. MOTHER'S MAIDEN NAME <b>GRACE COFFLEY</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-09-9495</b>	17. INFORMANT <b>Hospital records</b> ADDRESS <b>Lutheran Hospital, Baltimore Md.</b>		

18. <b>410X and 260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
(A) <b>MITRAL STENOSIS</b>		DUE TO		<b>4 years</b>
(B) <b>RHEUMATIC HEART DISEASE</b>		DUE TO		<b>4 years</b>
(C) <b>DIABETIC ACIDOSIS</b>				<b>one day</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Aug 10, 1953 to Aug 11, 1953, that I last saw the deceased alive on Aug 10, 1953, and that death occurred at m., from the causes and on the date stated above.

22A. SIGNATURE <b>Albert Subitely, M. D.</b>	22B. ADDRESS <b>5415 Park Heights Ave.</b>	22C. DATE SIGNED <b>Aug 11, 1953</b>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Aug 14, 1953</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland.</b>
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DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 13 1953</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>E. Truman Schurab</b>	ADDRESS <b>3512 Frederick Ave.</b>
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MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7265  
Registered No.

1. NAME OF DECEASED  
(Type or Print) **VIEOLA G. MEYERS**

2. DATE OF DEATH **Aug. 12. 1953**

3. PLACE OF DEATH:  
A. Baltimore City, Maryland  
B. FULL NAME OF HOSPITAL OR INSTITUTION  
**3906 4th. St.**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **MD**  
B. COUNTY  
C. CITY OR TOWN (If outside corporate limits write RURAL and give township)  
**BALTIMORE**

c. Length of stay in Baltimore  
67-Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)  
**3906 4th. St. — (Brooklyn)**

5. SEX **F.**  
6. COLOR OR RACE **W.**  
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **M**

8. DATE OF BIRTH **5-18-1886**  
9. AGE (in years last birthday) **67**  
If Under 1 Year Months: Days  
If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
**Housewife**

11. BIRTHPLACE (State or foreign country) **MD**  
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME  
**George W. Noble**

14. MOTHER'S MAIDEN NAME  
**MARGARET A. Jones**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) **No**  
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. **None**  
17. INFORMANT ADDRESS  
**Joseph G. Meyers 3906-4th. St.**

18. **422.1**  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
CAUSE OF DEATH  
(A) **Myocardial Insufficiency**  
DUE TO  
(B) **Atherosclerosis —**  
DUE TO  
(C) **Myocarditis**  
INTERVAL BETWEEN ONSET AND DEATH  
ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **0**  
19B. MAJOR FINDINGS OF OPERATION  
20. AUTOPSY? YES ☐ NO ☒  
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐  
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  
21E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☒  
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Feb 15**, 19**53**, to **Aug 12**, 19**53**, that I last saw the deceased alive on **8/9**, 19**53**, and that death occurred at **1035 A.m.**, from the causes and on the date stated above.

23A. SIGNATURE **John A. Schenck**  
23B. ADDRESS **1337 S. Charles St.**  
23C. DATE SIGNED **8/12/53**

24A. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL**  
24B. DATE **8.15.1953**  
24C. NAME OF CEMETERY OR CREMATORY **Mt. Olivet**  
24D. LOCATION (City, town, or county) (State) **BALTIMORE MD**

DATE RECEIVED BY LOCAL REGISTRAR **AUG 13 1953**  
REGISTRAR'S SIGNATURE **Huntington Williams, M.D.**  
25. FUNERAL DIRECTOR ADDRESS  
**2727 N. Broadway 3207 N. Broadway**

MEDICAL CERTIFICATION





P-532  
53 7266

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7266  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>CHARLES PENTZ</b>		2. DATE OF DEATH <b>8/12/53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>1313 S. CLINTON ST</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 26-36</b>	
c. Length of stay in Baltimore <b>40 YEARS</b>		D. STREET ADDRESS (If rural, give location) <b>1313 S. CLINTON ST</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>	8. DATE OF BIRTH <b>11/27/1900</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>WEISKETTEL CO</b>	9. AGE (In years last birthday) <b>52</b>
13. FATHER'S NAME <b>E.S. PENTZ</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. <b>214-03-3176</b>	14. MOTHER'S MAIDEN NAME <b>AMANDA RIGGINS</b>
18. <b>163X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CANCER OF LUNG</b>		17. INFORMANT ADDRESS <b>EDITH M. PENTZ 1313 S. CLINTON ST</b>	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION <b>CHRONIC BRONCHITIS</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21F. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <b>SEPT. 8, 1952</b> to <b>AUG. 12, 1953</b> that I last saw the deceased alive on <b>AUG. 12, 1953</b> and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.			
23A. SIGNATURE <b>Huntington Williams</b>		23B. ADDRESS <b>121 S. HIGHLAND AVE</b>	
23C. DATE SIGNED <b>8/12/53</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>8/15/53</b>	24C. NAME OF CEMETERY OR CREMATORY <b>SCHWARTZ'S</b>	24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 13 1953</b>		25. FUNERAL DIRECTOR ADDRESS <b>1634 Broadway</b>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 53 7267

1. NAME OF DECEASED  
(Type or Print)

AVON W. DAVIS SR.

2. DATE  
OF  
DEATH

8/11/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
A. STATE B. COUNTY before admission)

MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION PROVIDENT HOSPITAL  
1514 DIVISION ST.C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
BALTIMORE township)

D. STREET ADDRESS (If rural, give location)

1511 DRUID HILL AVE.

c. Length of stay in Baltimore

LIFE

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

4/10/1888

9. AGE (In years  
last birthday)

65

11 Under 1 Year 11 Under 24 Hours  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

RETIRED SUPT.

10B. KIND OF BUSINESS OR  
INDUSTRY

POSTAL DEPT.

11. BIRTHPLACE (State or foreign country)

BALTIMORE MD.

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

WINSLOW DAVIS

14. MOTHER'S MAIDEN NAME

ALICE CHRISTMAS

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

NO

16. SOCIAL  
SECURITY NO.

-

17. INFORMANT

ADDRESS

EDITH DAVIS(W) 1511 DRUID HILL AV.

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Hypertensive P.V. Disease

ANTECEDENT CAUSES

(B) DUE TO  
(C)DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II20. AUTOPSY?  
YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8 - 1, 1953 to 8 - 11, 1953 that I last saw the  
deceased alive on 8 - 11, 1953, and that death occurred at 5:45 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Perceval C. Smith

M. D.

23B. ADDRESS

1709 Gwynns Falls Pkwy

23C. DATE SIGNED

8-13-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

8/15/53

24C. NAME OF CEMETERY OR CREMATORY

MT. AUBURN CEM.

24D. LOCATION (City, town, or county)

BALTO. MD.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

AUG 13 1953

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

CHARLES G. COOPER-512 CARROLLTON  
AV.

ADDRESS

VS 150

29090 Charles H. Cooper

23 1987

1987

DAVID A. DAVIS

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L-552

53

7268

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7268

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Frederick Loehming

2. DATE  
OF  
DEATH

Aug. 13, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland 803 N. Milton Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY (5)

803 N. Milton Ave.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTIONC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Balto. Md.c. Length of stay in Baltimore  
Life Yrs. Mos. DaysD. STREET ADDRESS (If rural, give location)  
803 N. Milton Ave. (5)

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Widowed

8. DATE OF BIRTH

Oct. 20, 1880

9. AGE (In years last birthday)

72

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Upholster10B. KIND OF BUSINESS OR INDUSTRY  
Fallon & Heene Co.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Frederick Loehming

14. MOTHER'S MAIDEN NAME

Elizabeth Bowman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.  
213-03-1908

17. INFORMANT

ADDRESS

Mrs. Walter Carey 803 N. Milton Ave. (5)

18. 442X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
DUE TO

(A)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
DUE TO(B)  
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 10, 1950, to Aug 13, 1953, that I last saw the deceased alive on Aug 4, 1953, and that death occurred at 6:4 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 15/53

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cem

24D. LOCATION (City, town, or county)

Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR

AUG 13 1953

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Philip's Heury Sons

ADDRESS

2024 Orleans St

VS 150

59333

31

10.12.19

(1)

10.12.19

10.12.19

10.12.19

10.12.19

10.12.19

10.12.19



L-320

53 7269

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7269

1. NAME OF DECEASED (Type or Print) <u>Harvey Morgan LUTZ</u>			2. DATE OF DEATH <u>8/12/53</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Baltimore, Md.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>			C. CITY OR TOWN (If outside corporate limits, write full name and give township) <u>BALTIMORE</u>		
c. Length of stay in Baltimore <u>Life</u>			D. STREET ADDRESS (If rural, give location) <u>3540 BEECH AVE.</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. (SINGLE) MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>6/30/1910</u>	9. AGE (In years last birthday) <u>43</u>	If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) <u>BALTIMORE (Md.)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>CHARLES MILTON LUTZ</u>			14. MOTHER'S MAIDEN NAME <u>ELLEN LILY BLANCHÉ</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — ?		16. SOCIAL SECURITY NO. <u>220-14-9633</u>	17. INFORMANT <u>Lidia Blanché</u> ADDRESS <u>HANCOCK</u>		
18. <u>331X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CEREBRAL VASCULAR ACCIDENT</u> DUE TO (A) _____ (B) _____ (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>HYPERTENSION</u>			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION —		19B. MAJOR FINDINGS OF OPERATION —		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8/9</u> , 19 <u>53</u> , to <u>8/12</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>8/12</u> , 19 <u>53</u> , and that death occurred at <u>2:35</u> p.m., from the causes and on the date stated above.					
23A. SIGNATURE <u>Wm. L. Hill</u>		23B. ADDRESS <u>UNION MEM. HOSP.</u>		23C. DATE SIGNED <u>8/12/53</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Aug 15 1953</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Saudon Park Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		24E. DATE RECEIVED BY LOCAL REGISTRAR <u>AUG 13 1953</u>			
24F. REGISTRAR'S SIGNATURE <u>Wm. L. Hill</u>		24G. FUNERAL DIRECTOR <u>Paul E. Chenoweth</u>			
24H. ADDRESS <u>3615-17 Chesapeake Ave.</u>					

0887 73

CERTIFICATE OF DEATH

7380

808

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-260  
FW 173295  
53 7270  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7270  
Registered No.

1. NAME OF DECEASED (Type or Print)		Frank McCray		2. DATE OF DEATH 8-11-1953	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue		C. CITY OR TOWN (If outside corporate limits, write full name and give township) Baltimore 26-36			
31 5. Length of stay in Baltimore -		D. STREET ADDRESS (If rural, give location) 5717 Cardinal Lane #24			
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Separated		8. DATE OF BIRTH 8-4-1907 -	9. AGE (In years last birthday) 46
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY U.S. Government Furniture Outlet		11. BIRTHPLACE (State or foreign country) South Carolina	
13. FATHER'S NAME Charlie McCray		14. MOTHER'S MAIDEN NAME Mattie Thorn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. 223-05-9484		17. INFORMANT ADDRESS B.C.H. 4940 Eastern Aven. (records)	
18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Myocardial infarction DUE TO ANTECEDENT CAUSES (B) Coronary thrombosis DUE TO (C) Coronary Arteriosclerosis II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8-11-1953, to 8-11-1953 that I last saw the deceased alive on 8-11-1953, and that death occurred at 6:15 A.M., from the causes and on the date stated above.					
23A. SIGNATURE H. J. Williams		M. O. 4940 Eastern Avenue		23B. ADDRESS 4940 Eastern Avenue	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-16-53		24C. NAME OF CEMETERY OR CREMATORY Hycobaptist Church Cem. Richmond Va.	
DATE RECEIVED BY LOCAL REGISTRAR AUG 13 1953		REGISTRAR'S SIGNATURE Huntington Williams		25. FUNERAL DIRECTOR ADDRESS Charles R. Law, 802 Madison Ave.	

55484

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CERTIFICATE OF ADOPTION

1210

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B-346  
53 7272

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7272

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ELLEN HANSEN BUTLER</b>			2. DATE OF DEATH <b>8-13-53</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>yes</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Pennsylvania</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Maryland Gen. Hosp</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>5700</b>		
5. Length of stay in Baltimore <b>10</b> Yrs. <del>Months</del> <del>Days</del>			D. STREET ADDRESS (If rural, give location) <b>Canva Back Inn, Pennville</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 18, 1913</b>		9. AGE (In years last birthday) <b>40</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Colorado</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Chas. C. Hansen</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Davis</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Richard S. Butler</b>		ADDRESS <b>Canva Back Inn, Pennville</b>

18. <b>175X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <b>Intestinal Obstruction + 5 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>one week</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) <b>ovarian malignancy</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)		

19A. DATE OF OPERATION <b>8-13-53</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
TIME (Month) (Day) (Year) (Hour) <b>8-13-53</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7-8-53</b> , 19 <b>53</b> , to <b>8-13</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>8-13</b> , 19 <b>53</b> , and that death occurred at <b>9:12</b> Am., from the causes and on the date stated above.					
23A. SIGNATURE <b>William Sheng Lu</b>		23B. ADDRESS <b>Maryland Gen. Hosp.</b>		23C. DATE SIGNED <b>8-13-53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Marks Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Aikens, Cecil Co. Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 14 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>		25. FUNERAL DIRECTOR <b>John E. Darrington</b> <b>abernethy. Md.</b>	

MEDICAL CERTIFICATION

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side. Some words like "The" and "and" are faintly visible.]*

T-453  
53 7273BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

53 7273

BIRTH NO. 53-18408

1. NAME OF DECEASED  
(Type or Print)

Baby Girl Toland

2. DATE  
OF  
DEATH

8-5-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Maryland General Hosp.

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

single

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR  
INDUSTRY

none

13. FATHER'S NAME

Donald J. Toland Jr.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore - 13 26 03

D. STREET ADDRESS (If rural, give location)

3624 Emley Ave.

8. DATE OF BIRTH

8-5-53

9. AGE (in years  
last birthday)

0 0 30

11 Under 1 Year  
Months: Days

0 0 30

11 Under 24 Hours  
Hours: Min.

0 0 30

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Rita Zwirolein

17. INFORMANT

mother

ADDRESS

18. 754.4

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Respiratory failure  
DUE TO atelectasis

30 min

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) cardiac failure  
DUE TO cong. heart disease

30 min

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

possible diaphragmatic hernia

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-5-1953 to 8-5-1953, that I last saw the  
deceased alive on 8-5-1953, and that death occurred at 8:25 pm., from the causes and on the date stated above.

23A. SIGNATURE

R. K. Skipton

M. D.

23B. ADDRESS

Md. Gen. Hosp.

23C. DATE SIGNED

8-7-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

8/13/53

24C. NAME OF CEMETERY OR CREMATORY

Md. Gen'l Hospital

24D. LOCATION (City, town, or county)

Baltimore #1

(State)

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

7-2-53

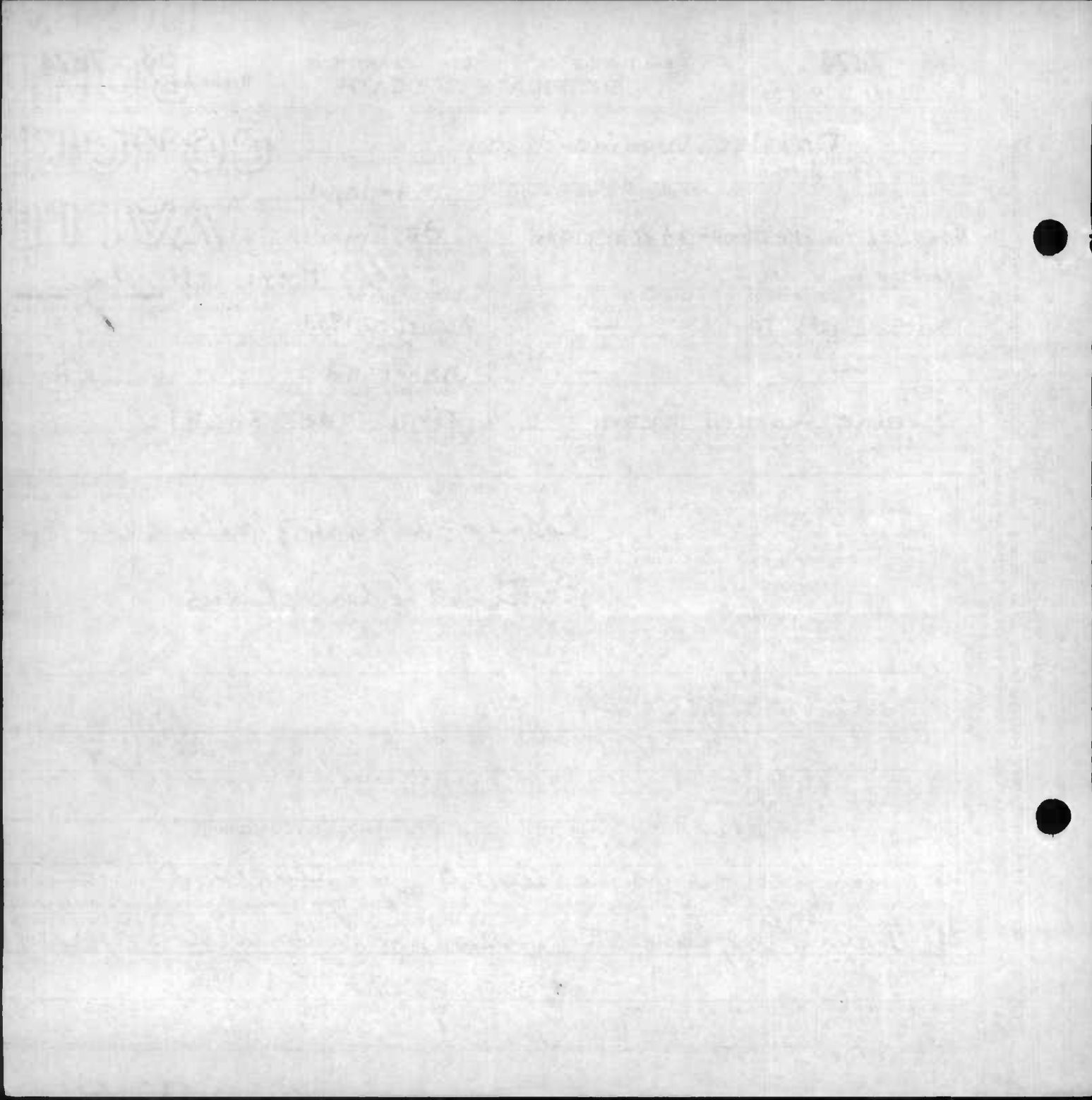
ADDRESS

Disposal



53 7274-16  
BIRTH NO. 53 7274  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH  
Registered No. 53 7274

1. NAME OF DECEASED (Type or Print) <b>Douglas Dwaine Ream</b>		2. DATE OF DEATH <b>August 12, 1953</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Hospital For The Women of Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 6 27-34</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		d. STREET ADDRESS (If rural, give location) <b>5406 Remmell Ave.</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>—</b>	8. DATE OF BIRTH <b>August 10, 1953</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	9. AGE (In years last birthday) <b>18</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dwaine Leonard Ream</b>		14. MOTHER'S MAIDEN NAME <b>Zina Mae Sherle</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	
18. <b>752X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cardio-respiratory failure 1 day 18 hrs</b> DUE TO <b>Dr. ter nal by discephalus</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19a. DATE OF OPERATION <b>7</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Aug 10</b> , 19 <b>53</b> , to <b>Aug 12</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>Aug 12</b> , 19 <b>53</b> , and that death occurred at <b>407</b> m., from the causes and on the date stated above.			
23a. SIGNATURE <b>William P. H. Lehart</b>		23b. ADDRESS <b>Hospital For Women 840</b>	23c. DATE SIGNED <b>8/12/53</b>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATOR	24d. LOCATION (City, town, or county) (State) <b>UNIVERSITY MEDICAL SCHOOL AUG 13 1953</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 14 1953</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams</b>	25. FUNERAL DIRECTOR <b>Huntington Williams, Md.</b>	ADDRESS





BIRTH NO. 53-18587		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 53 7275	
1. NAME OF DECEASED (Type or Print) <i>Baby Boy Underwood</i>			2. DATE OF DEATH <i>August 9, 1953</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Hospital for Women of Maryland</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Towson 4 5255</i>		
D. STREET ADDRESS (If rural, give location) <i>1549 Loch Shield Rd</i>			E. LENGTH OF STAY IN BALTIMORE <i>12 1/2</i>		
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) —	8. DATE OF BIRTH <i>August 9, 1953</i>	9. AGE (In years last birthday) <i>1 1/2</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —			10B. KIND OF BUSINESS OR INDUSTRY —		
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>			12. CITIZEN OF WHAT COUNTRY? —		
13. FATHER'S NAME <i>Frederic Underwood</i>			14. MOTHER'S MAIDEN NAME <i>Alla Benton</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) —			16. SOCIAL SECURITY NO. —		
17. INFORMANT			ADDRESS		
18. 762.5 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Anoxia</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 hr 5 mi</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Prematurity</i>			DUE TO (A) <i>Polyhydramnios</i> (B) <i>maternal</i> (C) —		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>Aug 9, 1953</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		19C. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Aug 9, 1953</i> , to <i>Aug 9, 1953</i> , that I last saw the deceased alive on <i>Aug 9, 1953</i> , and that death occurred at <i>3:45 p.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>William Phylelast</i>		23B. ADDRESS <i>St. Ann. for Women of Md.</i>		23C. DATE SIGNED <i>8/9/53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <i>UNIVERSITY MEDICAL SCHOOL</i>	
24D. LOCATION (City, town, or county) (State)		<i>AUG 13 1953</i>			
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 14 1953</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i>		25. FUNERAL DIRECTOR <i>Huntington Williams, M.D.</i>	
ADDRESS		ADDRESS			

1951

211

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7276

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7276

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Viola L. Schwartz

2. DATE  
OF  
DEATH

August 12, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)

INSTITUTION

3315 Elbert Street

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give  
township)

Baltimore

21-02

D. STREET ADDRESS (If rural, give location)

1210 Carroll Street

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Feb. 14, 1889

9. AGE (In years  
last birthday)

64

11 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Philadelphia, Pennsylvania

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William Thomas

14. MOTHER'S MAIDEN NAME

Mary Pross

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Lawrence L. Schwartz, 1210 Carroll Street

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Acute Pulmonary Edema  
DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerotic C.V.D.  
DUE TO  
(C)DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐  
WORKNOT WHILE ☐  
AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 31, 1953, to August 12, 1953, that I last saw the  
deceased alive on Aug. 12, 1953, and that death occurred at 7:45 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Joseph Beckelbaum, M.D.

23B. ADDRESS

4017 Liberty Hgts. Ave.

23C. DATE SIGNED

8-12-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8/15/53

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cemetery

24D. LOCATION (City, town, or county)

Baltimore,

Maryland

DATE RECEIVED BY  
LOCAL REGISTRAR

AUG 14 1953

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

2120 B &amp; B, Inc.

ADDRESS

1217 St. Paul Street



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No.	
C-625 53 7277		CARRIGAN X		53 7277	
1. NAME OF DECEASED (Type or Print)		Mrs. Helen Carrigan		2. DATE OF DEATH 8.13.53	
3. PLACE OF DEATH: A. Baltimore City, Maryland ✓		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		SAATO	
B. FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto., Md. Essex		O. STREET ADDRESS (If rural, give location) 231 Nanticoke Road 5354	
E. Length of stay in Baltimore 42 40 yrs		Yrs. Mos. Days			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 4-20-06	9. AGE (In years last birthday) 47	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Pa.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Stansbury		14. MOTHER'S MAIDEN NAME Anna Heiley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Joseph F. Carrigan	
18. 150X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) Pulmonary Embolism? and/or Pneumonia Rt. (B) Carcinoma Oesophagus. Collapse of Rt Lung with Hydropneumothorax (C) Tracheo-oesophageal fistula		INTERVAL BETWEEN ONSET AND DEATH about Six months	
19A. DATE OF OPERATION 7-29-53		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer oesophagus		19C. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from July 22, 1953 to Aug 13, 1953 that I last saw the deceased alive on 8.12.1953, and that death occurred at 12:40 a.m., from the causes and on the date stated above.			
23A. SIGNATURE J. C. Chandrasekhar		23B. ADDRESS Sinai Hospital, Baltimore		23C. DATE SIGNED 8.13.53	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-17-53		24C. NAME OF CEMETERY OR CREMATORY St. Mary's	
24D. LOCATION (City, town, or county) (State) Harford County Md.		25. FUNERAL DIRECTOR Huntington Williams & Co., Inc. 403 S. Wolfe Street			

AUG 14 1953  
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CERTIFICATE OF DEATH

1757

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W-160  
53 7278BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7278  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Caroline (Carrie) Weaver

2. DATE  
OF  
DEATH

8-12-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Balto

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

721 S. Durham Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore, Md.

2-03

D. STREET ADDRESS (If rural, give location)

721 S. Durham Street

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

6-13-89

9. AGE (In years  
last birthday)

64

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

? Frank

14. MOTHER'S MAIDEN NAME

Minnie Ganzewiler

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT  
Frank Aendzierski

ADDRESS

721 S. Durham Street

18. 57015

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

Acute Internal Obstruction 3 days

INTERVAL BETWEEN  
ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Chronic Hypertrophic Atherosclerosis

?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 10, 1953, Aug 12, 1953 that I last saw the deceased alive on Aug. 12, 1953, and that death occurred at 3 P. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

8-15-53

Mt. Carmel

Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 14 1953

Huntington W. Bickel, M.D.

Lilly &amp; Zeiler, Inc. 403 S. Wolfe Street



G-240

53 7279

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7279

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Louise ISRAEL Gesell

2. DATE  
OF  
DEATH

AUGUST 12, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Mercy Hospital

C. Length of stay in Baltimore

65

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Female

White

Married

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

Housewife

13. FATHER'S NAME

WILLIAM ISRAEL

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

1-01

D. STREET ADDRESS (If rural, give location)

1014 S. Decker Ave (29)

8. DATE OF BIRTH

3/23/88

9. AGE (In years  
last birthday)

65

11 Under 1 Year  
Months Days11 Under 24 Hours  
Hours Min.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

14. MOTHER'S MAIDEN NAME

Annette Haines

17. INFORMANT

ADDRESS

Arthur H. Gesell - Sr. same

18. 581.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Hepatic coma

DUE TO

48 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Cirrhosis of liver

DUE TO

Indefinite

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from 8/10, 1953, to 8/12, 1953, that I last saw the  
deceased alive on 8/12, 1953, and that death occurred at 12<sup>45</sup> P. m., from the causes and on the date stated above.

23A. SIGNATURE

Harvey S. Greck

M. D.

23B. ADDRESS

MERCY HOSPITAL

23C. DATE SIGNED

8/12/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

8-15-53

Oak Lawn

Balto. Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 14 1953

Huntington Williams, M.D. Lilly & Zeller of ne 403 S  
Wolfe St.

UNITED STATES DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1977

1. Name of deceased		2. Sex		3. Race	
4. Date of birth		5. Date of death		6. Place of death	
7. Usual residence		8. Cause of death		9. Manner of death	
10. Physician		11. Hospital		12. Burial place	
13. Signature of physician		14. Signature of registrar		15. Signature of medical examiner	
16. Signature of funeral director		17. Signature of coroner		18. Signature of justice of the peace	
19. Signature of health officer		20. Signature of state health officer		21. Signature of federal health officer	
22. Signature of local health officer		23. Signature of local health officer		24. Signature of local health officer	
25. Signature of local health officer		26. Signature of local health officer		27. Signature of local health officer	
28. Signature of local health officer		29. Signature of local health officer		30. Signature of local health officer	
31. Signature of local health officer		32. Signature of local health officer		33. Signature of local health officer	
34. Signature of local health officer		35. Signature of local health officer		36. Signature of local health officer	
37. Signature of local health officer		38. Signature of local health officer		39. Signature of local health officer	
40. Signature of local health officer		41. Signature of local health officer		42. Signature of local health officer	
43. Signature of local health officer		44. Signature of local health officer		45. Signature of local health officer	
46. Signature of local health officer		47. Signature of local health officer		48. Signature of local health officer	
49. Signature of local health officer		50. Signature of local health officer		51. Signature of local health officer	
52. Signature of local health officer		53. Signature of local health officer		54. Signature of local health officer	
55. Signature of local health officer		56. Signature of local health officer		57. Signature of local health officer	
58. Signature of local health officer		59. Signature of local health officer		60. Signature of local health officer	
61. Signature of local health officer		62. Signature of local health officer		63. Signature of local health officer	
64. Signature of local health officer		65. Signature of local health officer		66. Signature of local health officer	
67. Signature of local health officer		68. Signature of local health officer		69. Signature of local health officer	
70. Signature of local health officer		71. Signature of local health officer		72. Signature of local health officer	
73. Signature of local health officer		74. Signature of local health officer		75. Signature of local health officer	
76. Signature of local health officer		77. Signature of local health officer		78. Signature of local health officer	
79. Signature of local health officer		80. Signature of local health officer		81. Signature of local health officer	
82. Signature of local health officer		83. Signature of local health officer		84. Signature of local health officer	
85. Signature of local health officer		86. Signature of local health officer		87. Signature of local health officer	
88. Signature of local health officer		89. Signature of local health officer		90. Signature of local health officer	
91. Signature of local health officer		92. Signature of local health officer		93. Signature of local health officer	
94. Signature of local health officer		95. Signature of local health officer		96. Signature of local health officer	
97. Signature of local health officer		98. Signature of local health officer		99. Signature of local health officer	
100. Signature of local health officer		101. Signature of local health officer		102. Signature of local health officer	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 53-728053 7280  
BIRTH NO.1. NAME OF DECEASED  
(Type or Print)

MEYER SOLOMON

2. DATE  
OF  
DEATH

8/14/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

SINAI HOSPITAL OF BALTO. INC.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

3-01

D. STREET ADDRESS (If rural, give location)

1523 E. BALTIMORE ST.

4. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

8/4/77 (?)

9. AGE (In years last birthday)

76

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Merchant

10B. KIND OF BUSINESS OR INDUSTRY

confectionery

11. BIRTHPLACE (State or foreign country)

ROMANIA

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Morris

14. MOTHER'S MAIDEN NAME

Blanca

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

UNKNOWN

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Harry Solomon - Same

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRO-VASCULAR ACCIDENT

48 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/12, 1953, to 8/14, 1953, that I last saw the deceased alive on 8/14, 1953, and that death occurred at 4:40 Am., from the causes and on the date stated above.

23A. SIGNATURE

Stanley B. Gould

M. D.

23B. ADDRESS

Sinai Hospital Balto.

23C. DATE SIGNED

8/14/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-14-53

24C. NAME OF CEMETERY OR CREMATORY

Southern Ave

24D. LOCATION (City, town, or county)

Balto.

(State)

Md.

DATE RECEIVED BY LOCAL REGISTRAR

4/1/53

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

J. L. Lewis, Inc. - 2100 Eutaw Pl.

ADDRESS

0857-20-101

CERTIFICATE OF DEATH

0857-20-101

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H-656  
53 7281BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7281  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		Mrs. Susie F. Horner		August 12, 1953	
3. PLACE OF DEATH:		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
A. Baltimore City, Maryland		A. STATE Maryland B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)			
Long Green Nursing Home 115 E. Melrose Avenue		Baltimore 13-06			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location)			
10 years		847 W. 34th Street			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Year Months: Days
Female	White	Widow	June 11, 1880	73	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
At Home				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Charles F. Hoover		Mary Good		U S A	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				L. Franklin Price, Timonium, Maryland	
18. 151X		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Carcinoma of Stomach			
ANTECEDENT CAUSES		INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		6 mo.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1-23, 1951, to 8-12, 1953, that I last saw the deceased alive on 8-12, 1953 and that death occurred at 4:50 p.m., from the causes and on the date stated above.					
23A. SIGNATURE		23B. ADDRESS		23C. DATE SIGNED	
Neuken Hoffman		846 W. 36th St.		8-13-53	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		Aug. 15, 1953		Jessops	
24D. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR ADDRESS			
Baltimore Co., Maryland		Horace F. Burge		3631 Falls Road	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE			
AUG 14 1953		Huntington Williams			

1887

83

1887

83

**53 7282** BALTIMORE CITY HEALTH DEPARTMENT **53 7282**  
**CERTIFICATE OF DEATH** Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>EDITH SPICER</b>		2. DATE OF DEATH <b>8/12/53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 21-02</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>855 W. OSTEND ST.</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>JAN. 31, 1884 69</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>69</b> If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
11. BIRTHPLACE (State of foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Saunders</b>		14. MOTHER'S MAIDEN NAME <b>Mary Lee</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hiram H. Sharp</b>		ADDRESS <b>855 Ostend</b>	
18. <b>592X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Hemorrhage</b>		CAUSE OF DEATH <b>Cerebral Hemorrhage</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Hypertension</b>		DUE TO <b>Chronic Glomerulonephritis</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20. AUTOPSY? CAUSE OF DEATH, ENTER IN PART I OR PART II YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>8/10</b> 19 <b>53</b> , to <b>8/12</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>8/12</b> , 19 <b>53</b> , and that death occurred at <b>4 P</b> m., from the causes and on the date stated above.			
23A. SIGNATURE <b>John F. Strahan</b>		23B. ADDRESS <b>University Hosp.</b>	
23C. DATE SIGNED <b>8/13/53</b>		24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>8/16/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt Zion</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>		25. FUNERAL DIRECTOR <b>Charles A. Rice</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 14 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington</b>	
25. FUNERAL DIRECTOR <b>Charles A. Rice</b>		ADDRESS <b>66 W. Barre St.</b>	

VS 150

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5851

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RECORDS OF  
THE  
COMMISSION  
AND  
THE  
JURY

5-352  
53 7283  
BIRTH NO. 53-18392

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7283  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Baby Boy Stengel</i>			2. DATE OF DEATH <i>8-6-53</i>		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY		
b. FULL NAME OF HOSPITAL OR INSTITUTION <i>Ind. General Hosp.</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto. - 17 14-01</i>		
c. Month of stay in Baltimore			d. STREET ADDRESS (If rural, give location) <i>1615 Euton Ave</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>8/2/53</i>		9. AGE (In years last birthday) <i>4</i> H Under 1 Year Months: Days: H Under 24 Hours Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, <del>was</del> if retired) <i>none</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Ind.</i>
13. FATHER'S NAME <i>Richard Stengel</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>none</i>		
17. INFORMANT <i>Mother</i>			ADDRESS		

18. <i>776x</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Immaturity</i> DUE TO <i>prematurity</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.		

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>8-2</i> , 19 <i>53</i> , to <i>8-6</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>8-6</i> , 19 <i>53</i> and that death occurred at <i>3:15 a. m.</i> , from the causes and on the date stated above.				
23A. SIGNATURE <i>H. K. Skipton</i>		23B. ADDRESS <i>Ind. Gen. Hosp.</i>		23C. DATE SIGNED <i>8-6-53</i>

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 14 1953</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>	25. FUNERAL DIRECTOR <i>Huntington Williams, Md.</i>

THE UNIVERSITY OF CHICAGO

1885

1885

THE UNIVERSITY OF CHICAGO

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THE UNIVERSITY OF CHICAGO



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

53 7284

BIRTH NO. 53 7284 3-18588

1. NAME OF DECEASED  
(Type or Print)

Baby Boy Underwood

2. DATE  
OF  
DEATH

August 9, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland B. COUNTY Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Hospital for Women of Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Towson 4 5355

C. Length of stay in Baltimore

D. STREET ADDRESS (If rural, give location)

1849 Lock Shield Rd

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

August 9, 1953

9. AGE (In years  
last birthday)

6

If Under 1 Year  
Months: Days

6 34

If Under 24 Hours  
Hours: Min.

6 34

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Frederic Underwood

14. MOTHER'S MAIDEN NAME

Alla Denton

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 762.5 I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) Anoxia  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Prematurity  
DUE TO  
(C) Maternal PolyhydramniosINTERVAL BETWEEN  
ONSET AND DEATH

6h 34m.

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 9, 1953, to Aug 9, 1953, that I last saw the  
deceased alive on Aug 9, 1953, and that death occurred at 8:55 p.m., from the causes and on the date stated above.

23A. SIGNATURE

William P. Pyle

23B. ADDRESS

Hosp. for Women 4d

23C. DATE SIGNED

8/9/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

UNIVERSITY MEDICAL SCHOOL AUG 13 1953  
FUNDAMENTAL DIRECTOR

ADDRESS

1935

10

1935

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1935

1935

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
53 7285		CERTIFICATE OF DEATH		53 7285	
1. NAME OF DECEASED (Type or Print)			2. DATE OF DEATH		
JOHN C. HILL			August 13, 1953		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
B. FULL NAME OF (not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION			A. STATE B. COUNTY		
University Hospital			Maryland		
C. Length of stay in Baltimore			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
35 yrs.			Baltimore 15-02		
D. STREET ADDRESS (If rural, give location)			1708 Laurens Street		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months Days
male	colored		1892	56	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
Contractor					
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Moses Hill			Fannie ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT			ADDRESS		
Phyllis Hill			1708 Laurens St		
18. 581.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
			(A) Hypertensive cardiovascular disease		
ANTECEDENT CAUSES			DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) Fatty metamorphosis of the liver		
			DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C)		
19A. DATE OF OPERATION			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that I took charge of the remains described above, held an <u>Partial Autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE			23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		
Joseph A. Jachimczyk			8/14/53		
24A. BURIAL, CREMATION, REMOVAL (Specify)			24B. DATE		
Burial			8/17/53		
24C. NAME OF CEMETERY OR CREMATORY			24D. LOCATION (City, town, or county) (State)		
Mt. Auburn Cn.			West of Balto.		
DATE RECEIVED BY LOCAL REGISTRAR			REGISTRAR'S SIGNATURE		
AUG 14 1953			Huntington Williams		
25. FUNERAL DIRECTOR			ADDRESS		
Metropolitan Funeral Home Inc.			29024 1949 Edmondson Ave		

1883

73

STATE OF NEW YORK

1883

73

R-520  
53 7286

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7286  
Registered No.

1. NAME OF DECEASED (Type or Print) <u>Ring, Wesley W.</u>		2. DATE OF DEATH <u>13 August 1953</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Baltimore City</u>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>md</u> B. COUNTY <u>Balto</u>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <u>Franklin Square No 5221 Arbutus Ave</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>	
D. STREET ADDRESS (If rural, give location) <u>5300</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>May 24-1889</u>	
9. AGE (in years last birthday) <u>64</u>		10. MONTHS <u>1</u> YEARS <u>1</u> UNDER 24 HOURS <u>1</u> UNDER 24 HOURS <u>1</u> MIN.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, also if retired) <u>Retired Merchant</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Meat</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W Ring</u>		14. MOTHER'S MAIDEN NAME <u>Ely abelha King</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219--878</u>	
17. INFORMANT <u>Wesley W Ring 5221 Arbutus Ave</u>		18. 540.0 <u>8-11-39</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO <u>BLEEDING PEPTIC ULCER</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO <u>ARTERIOSCLEROSIS</u> <u>1.5 yrs</u>		(C) <u>HYPERTENSION (ARTERIAL)</u> <u>20 yrs.</u>	
19A. DATE OF OPERATION <u>Aug 15-53</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u>Burial</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>London Park</u>	
21C. WHERE DID INJURY OCCUR? <u>Frederick Rd</u>		21D. TIME (Month) (Day) (Year) (Hour) <u>Aug 15-53</u>	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>2906A</u>	
22. I hereby certify that I attended the deceased from <u>11 August, 1953</u> to <u>13 August, 1953</u> , that I last saw the deceased alive on <u>13 August 1953</u> , and that death occurred at <u>11:15 A.m.</u> , from the causes and on the date stated above.			
23A. SIGNATURE <u>Felix P. Moray</u>		23B. ADDRESS <u>Franklin Square Hospital</u>	
23C. DATE SIGNED <u>13 August 1953</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Aug 15-53</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		24D. LOCATION (City, town, or county) (State) <u>Frederick Rd</u>	
25. FUNERAL DIRECTOR <u>Huntington</u>		ADDRESS <u>Edwardoulson Balto 30 md</u>	

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83 7580

THE UNITED STATES OF AMERICA

CERTIFICATE OF DEATH

83 7580

83 7580

*[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JULIA REBECCA WISE

2. DATE  
OF  
DEATH

Aug. 12, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Apt. 113 Greenway Apts.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

Apr. 30, 1861

9. AGE (In years;  
last birthday)

92

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR  
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Reisterstown, Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

David Uhler

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS

Mr. W. G. Conwell

Above

18.

331X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

cerebral vascular accident

3 days

ANTECEDENT CAUSES

DUE TO

(B)

arteriosclerosis

? yrs

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/25/30, 19, to 8/12/53, 19, that I last saw the  
deceased alive on 8/12/53, 19, and that death occurred at 6 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Francis W. Gluck

23B. ADDRESS

M. D.

100 W University Park

23C. DATE SIGNED

8/13/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8/14/53

24C. NAME OF CEMETERY OR CREMATORY

LXXXXX

Loudon Pk.

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Huntington William M. P. M. J. Baker - Son Inc Balto Md

AUG 14 1953  
VS 150

1857 32

1857 32



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-252  
53 7288BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7288  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HARRY H. HAWKINS

2. DATE  
OF  
DEATH

August 13, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)A. STATE  
MarylandB. FULL NAME OF (If not in hospital or institution, give street address or  
location)  
HOSPITAL OR  
INSTITUTION

3909 Gwynns Falls Parkway

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3909 Gwynns Falls Parkway

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

Feb. 28, 1871

9. AGE (In years,  
last birthday)

82

10. Under 1 Year  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Farmer

10B. KIND OF BUSINESS OR  
INDUSTRY

Self-Retired

11. BIRTHPLACE (State or foreign country)

A. A. Co., Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Joshua Hawkins

14. MOTHER'S MAIDEN NAME

Anne Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS Pkwy.

Miss Bessie I. Hawkins-3909 Gwynns Falls

18. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) *Cerebral embolism*

DUE TO

*Myocarditis*

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) *Generalized arteriosclerosis*

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐  
WORKNOT WHILE ☐  
AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 13, 1953, to Aug 12, 1953, that I last saw the  
deceased alive on Aug 13, 1953, and that death occurred at 3 P. m., from the causes and on the date stated above.

23A. SIGNATURE

N. E. Needle

23B. ADDRESS

4415 Park Heights Ave

23C. DATE SIGNED

8-13-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8-14-53

24C. NAME OF CEMETERY OR CREMATORY

Meadowridge Memorial Park

24D. LOCATION (City, town, or county)

Howard County, Maryland

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

Wm. J. Pickner &amp; Sons

ADDRESS

North Penna Ave  
- Baltimore-17, Md.

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53 7289

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7289

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)~~Leila~~ Burbank - LEILA G.2. DATE  
OF  
DEATH

8/13/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

MD

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1906 WARNICK AVE

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

Oct. 17, 1871

9. AGE (In years  
last birthday)

81

10. Under 1 Year  
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

HOME

10B. KIND OF BUSINESS OR  
INDUSTRY

NONE

11. BIRTHPLACE (State or foreign country)

No

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILLIAM HINKLE NORRIS

14. MOTHER'S MAIDEN NAME

LYDIA GRAY ~~Norris~~ NORRIS15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 443X and 153X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Acute Myocardial Infarction

5 min

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Hypertensive Cardiovascular disease

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Carcinoma ascending colon

19A. DATE OF OPERATION

8/5/53

19B. MAJOR FINDINGS OF OPERATION

Carcinoma ascending colon. Inflammatory polyps sigmoid

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

21G. WHILE AT  
WORK

m.

NOT WHILE  
AT WORK22. I hereby certify that I attended the deceased from 8/5/53, 19, to 8/13/53, 19, that I last saw the  
deceased alive on 8/13, 1953, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

Peter Christoph

M. O.

23B. ADDRESS

Sinai Hospital

23C. DATE SIGNED

8/13/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

8/5/53

24C. NAME OF CEMETERY OR CREMATORY

DAVID RIDGE CEM

24D. LOCATION (City, town, or county)

PIKEVILLE MD

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

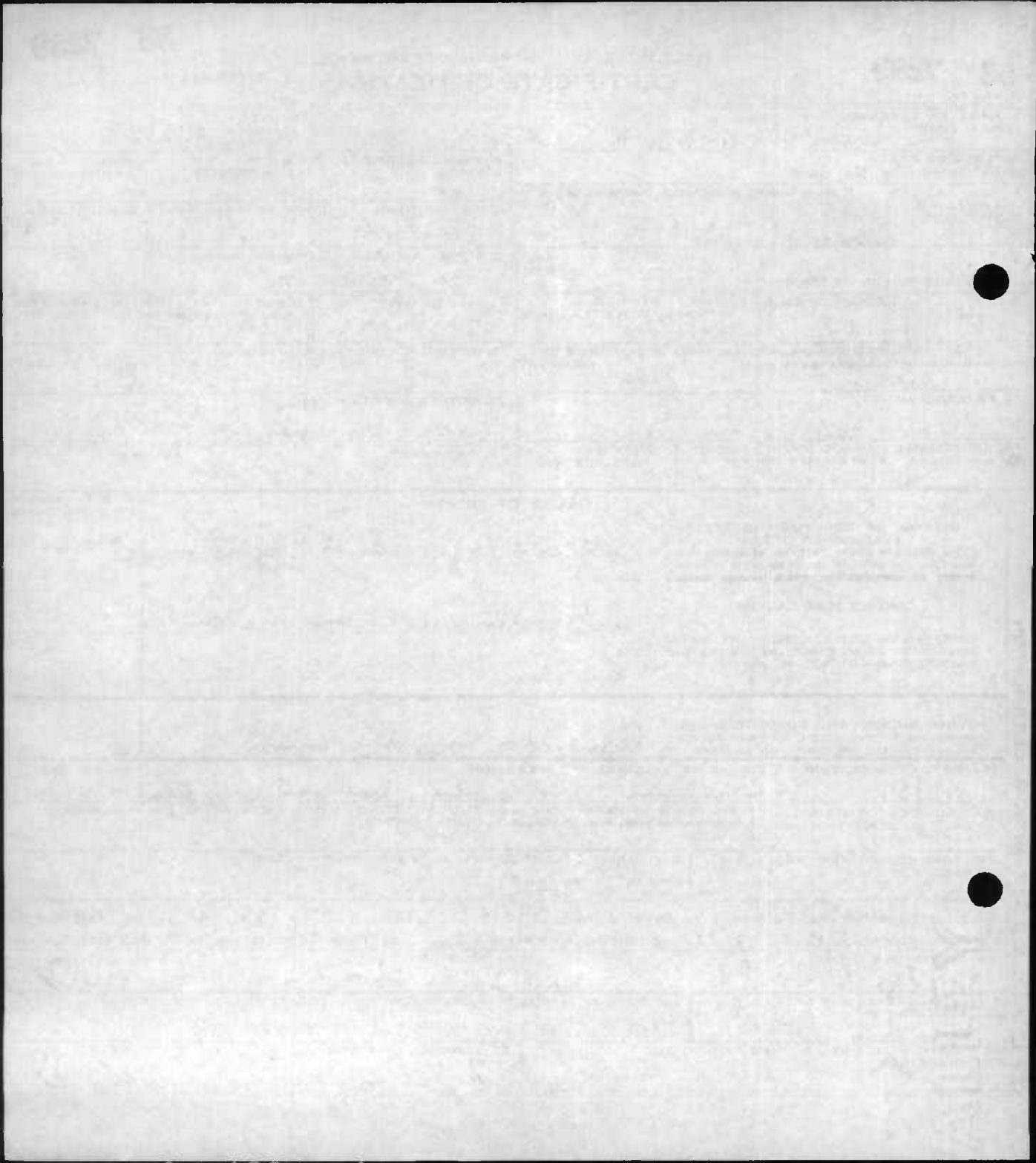
ADDRESS

AUG 14 1953

Huntington 5/10/1953 Wm. P. Pickens &amp; Sons, Inc. Balto Md

VS 150

MEDICAL CERTIFICATION





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7290

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

53 7290

Registered No.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
MARY LOUISE ROTT		Aug. 12, 1953	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md.	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 2859 Woodbrook Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 2859 Woodbrook Ave.	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 3, 1878
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10B. KIND OF BUSINESS OR INDUSTRY Home	9. AGE (In years last birthday) 74
13. FATHER'S NAME Nicholas Hoffman		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		12. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY NO. None		14. MOTHER'S MAIDEN NAME Agnes Schultz	
17. INFORMANT Mrs. Agnes Hewett		ADDRESS Above	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cerebral Hemorrhage DUE TO (B) Hypertension DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 3 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 10, 1957, to Aug. 12, 1953, that I last saw the deceased alive on Aug 12, 1953, and that death occurred at m., from the causes and on the date stated above.			
23A. SIGNATURE George A. Shannon M.D.		23B. ADDRESS 820 Medical Arts Bldg	
23C. DATE SIGNED 9/13/53			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/15/53	
24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE RECEIVED BY LOCAL REGISTRAR		25. FUNERAL DIRECTOR ADDRESS H. F. 9-5131-2nd St. Balt. Md.	

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0857 20

BALTIMORE CITY HEALTH DEPARTMENT				53 7291	
CERTIFICATE OF DEATH				Registered No.	
1. NAME OF DECEASED (Type or Print) <i>Walter Parker</i>				2. DATE OF DEATH <i>Aug 12, 1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Acc Room</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Ind.</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 8-06</i>	
D. STREET ADDRESS (If rural, give location) <i>1742 E. Oliver St</i>				E. Length of stay in Baltimore <i>Life</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>3-1-1883</i>	9. AGE (In years last birthday) <i>70</i>	If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Jobbing</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Self employed</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Walter Parker</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-03-9714</i>		17. INFORMANT ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>	
18. <i>331X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral Vasc. Accident</i>				INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				CERTIFICATION APPROVED BY <i>Joseph G. Jackson</i> M.D. CHIEF OR ASST. MEDICAL EXAMINER	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>8/12</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>8/12</i> , 19 <i>53</i> , to <i>8/12</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>8/12</i> , 19 <i>53</i> , and that death occurred at <i>10:23 P.</i> from the causes and on the date stated above.					
23A. SIGNATURE <i>W.E. Mattis</i>		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>Aug 13, 1953</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-16-1953</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Arbutus Memorial Pk.</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		25. FUNERAL DIRECTOR ADDRESS <i>Huntington Williams, M.D. 1412 E. Preston St.</i>			
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 14 1953</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i>			
VS 150 To be approved by MEDICAL EXAMINER					

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H-322  
53 7292

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7292  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		Hedges, LeRoy Leightner		August 12, 1953	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore			
B. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 4602 York Road			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan 14 1888	9. AGE (in years last birthday) 65	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Funeral Director		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel J. Hedges		14. MOTHER'S MAIDEN NAME Laura E. Cole	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Minnie P. Hedges	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 581.0 and 260x CIRRHOSIS OF THE LIVER		CAUSE OF DEATH (A) Cirrhosis of the liver (B) Diabetes mellitus (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (Minute) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from August 11, 1953 to August 12, 1953 that I last saw the deceased alive on August 12, 1953, and that death occurred at 9:10 a.m., from the causes and on the date stated above.					
23A. SIGNATURE R. Cassinelli		23B. ADDRESS M. D. 1100 N. Caroline Street		23C. DATE SIGNED Aug. 12, 1953	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug 15, 1953		24C. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer Cem.	
24D. LOCATION (City, town, or county) 4430 Belair Road		24E. DATE RECEIVED BY LOCAL REGISTRAR AUG 14 1953		24F. REGISTRAR'S SIGNATURE Huntington W. Williams	
24G. FUNERAL DIRECTOR McHenry W. Jenkins & Sons Co.		24H. ADDRESS 4905 York Rd.		24I. 054FF	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

BALTIMORE CIVIL HEALTH DEPARTMENT

1935

1935

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-173072 AB  
53 B 7293  
BIRTH NO.

BIAVOS  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 7293

1. NAME OF DECEASED (Type or Print) <b>Irene Blavos</b>			2. DATE OF DEATH <b>8-12-1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Dundalk</b>		
c. Length of stay in Baltimore <b>18 months</b> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>2525 Yorkway</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 12-1887</b>	9. AGE (In years last birthday) <b>66</b>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME <b>Spyro</b>			14. MOTHER'S MAIDEN NAME <b>Mamonaki</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT <b>4940 Eastern Ave.</b> ADDRESS <b>Records: Baltimore City Hospitals</b>		

18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Cerebro-Vascular Accident</b> DUE TO ANTECEDENT CAUSES (B) <b>Hypertensive Cardio-Vascular Disease</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <b>7</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **8-5**, **1953**, to **8-12**, **1953**, that I last saw the deceased alive on **8-12**, **1953**, and that death occurred at **6.30AM**, from the causes and on the date stated above.

23A. SIGNATURE **H. John Doe** M. D. **4940 Eastern Ave., Baltimore, Md.** 23B. ADDRESS **8-12-1953** 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8-15-53</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Greek Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Windsor Mill Rd.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 14 1953</b>		25. FUNERAL DIRECTOR <b>Lampros Funeral Home Inc.</b> <b>440 E. North Av.</b>	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7294

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7294

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Charles Cooper

2. DATE  
OF  
DEATH

Aug 12, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

605 N. Belvidere Ave

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

6-20-79

9. AGE (In years  
last birthday)

74

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

WATCH MAN

10B. KIND OF BUSINESS OR  
INDUSTRY

BAKERY

11. BIRTHPLACE (State or foreign country)

MARY LAND

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

JOHN COOPER

14. MOTHER'S MAIDEN NAME

ELIZABETH GRUIVER

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

DUE TO

(A) Subdural hematoma, Sclerosing meningitis?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B) No history antecedent to cause

(C) Hypertensive cardiac vascular disease

CERTIFICATION APPROVED BY

William H. D.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDCHIEF OR ASSISTANT MEDICAL EXAMINER  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 12, 1953 to Aug 12, 1953 that I last saw the  
deceased alive on Aug 12, 1953 and that death occurred at 11:10 a. m. from the causes and on the date stated above.

23A. SIGNATURE

Edward P. Oberlander Jr.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

12 Aug 1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

AUG 15, 1953

24C. NAME OF CEMETERY OR CREMATORY

BALTIMORE

24D. LOCATION (City, town, or county)

BALTIMORE MD

DATE RECEIVED BY  
LOCAL REGISTRAR

AUG 14 1953

REGISTRAR'S SIGNATURE

Huntington Whitehead, Jr.

25. FUNERAL DIRECTOR

ULLRICH FUNERAL HOME 4210 BELAIR

VS. 150

To be approved by Medical Examiner 76344

1951

1951

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WATLEY

WATLEY

WATLEY

WATLEY

WATLEY

WATLEY

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

53 7295

CERTIFICATE OF DEATH

53 7295  
Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	MARYLAND	STATE	Maryland. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	BALTIMORE 40 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	BALTIMORE 8-03
HOSPITAL OR INSTITUTION OR STREET ADDRESS	2622 E. Biddle St.	STREET ADDRESS	(If rural give location) 2622 E. Biddle St.
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH:	
(First) VIOLA (Middle) MAY (Last) GUNTHER		(Month) 8 (Day) 12 (Year) 1953	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
F	W	MARRIED	5/27/1893
9. AGE last birthday:		10. BIRTHPLACE (State or foreign country):	
60 yrs.		Maryland	
11. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE		U.S.A.	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
SIMON ALEXANDER		MINNIE KRAUSE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.:	
No		P	
17. INFORMANT & ADDRESS:		Walter Stanley Gunther - 2622 E. Biddle	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
Immediate cause (a) Carcinoma of Uterus.		?	
Antecedent causes (s) (b) DUE TO			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) DUE TO			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY ?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/> HOW DID INJURY OCCUR ?	
22. I hereby certify that I attended the deceased from 8/1/1953, to 8/12/1953, that I last saw the deceased alive on 8/11/1953, and that death occurred at 11:30 PM from the causes and on the date stated above.			
SIGNATURE M. K. Quinn		ADDRESS 8358 Loch Raven Blvd. 8/13/53	
M.D.			
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
Burial		Mt Olivet	
DATE REC'D BY LOCAL REGISTRAR		LOCATION (City, town, or county) (State)	
AUG 14 1953		Firedrill Ave	
REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
Huntington Williams, M.D.		ADDRESS	
		1701-03 N. Patterson Park Ave	





S-200  
53 7296

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7296  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Francis Scheck</i>		2. DATE OF DEATH <i>8-13-53</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1000 Caton Avenue</i>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Jenkins Memorial Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write full township) <i>Baltimore</i>			
C. Length of stay in Baltimore <i>84</i>		D. STREET ADDRESS (If rural, give location) <i>800 Engine Court - Brooklyn Md.</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>W</i>	8. DATE OF BIRTH <i>6-20-1869</i>	9. AGE (In years last birthday) <i>84 yrs.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>	
13. FATHER'S NAME <i>Francis J. Scheck</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.C.</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Schneider</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>May Kammer-716 Holler Rd. #12</i>	

18. <i>443X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Hypertensive cardiovascular d. &amp; failure &amp; auricular fibrillation</i>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Padgett's disease</i>		

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>July 1</i> , 19 <i>53</i> , to <i>Aug 13</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>Aug 13</i> , 19 <i>53</i> , and that death occurred at <i>6:00 P</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>James E. Rowe Jr.</i>		23B. ADDRESS <i>St Agnes Hosp.</i>		23C. DATE SIGNED <i>8/13/53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Aug. 17, 1953</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Em.</i>	
24D. LOCATION (City, town, or county) <i>Belair Rd. - Balto. Md.</i>		24E. DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 14 1953</i>		24F. REGISTRAR'S SIGNATURE <i>Huntington W. Brainerd, M.D.</i>	
25. FUNERAL DIRECTOR <i>John C. Miller Inc.</i>		25A. ADDRESS <i>2431 E. Oliver St. #13</i>			

MEDICAL CERTIFICATION

1908

RECEIVED THE SECRETARY OF THE  
NAVY DEPARTMENT

1908

1908

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-600		CERTIFICATE CORRECTED		8-19-53	
53 7297		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 53 7297	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>BERRY, Annie Wray</b>			2. DATE OF DEATH <b>Aug. 14, 1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Queen Anne's</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>US PHS Hospital Baltimore 11, Maryland</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <b>Queenstown</b>		
57 c. Length of stay in Baltimore <b>2</b> Yrs. <b>5</b> Mos. <b>1</b> Days			D. STREET ADDRESS (If rural, give location) <b>---</b> <b>6700</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>7-11-81</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>George Tipping</b>			14. MOTHER'S MAIDEN NAME <b>Priscilla Wray</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-05-4682</b>	17. INFORMANT ADDRESS <b>Records, US PHS Hospital, Balto. 11, Md.</b>		
18. <b>170X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Adenocarcinoma of breast with metastasis.</b>			INTERVAL BETWEEN ONSET AND DEATH approxi. <b>15 months</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7-1-1953</b> to <b>8-14-1953</b> , that I last saw the deceased alive on <b>8-14-1953</b> , and that death occurred at <b>12:10 P.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>J.A. Hunter</b> J.A. Hunter, Medical Director		23B. ADDRESS <b>US PHS Hospital, Balto. 11, Md.</b>		23C. DATE SIGNED <b>8-14-53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>8/17/53</b>	24C. NAME OF CEMETERY OR CREMATORY <b>CHESTER FIELD</b>	24D. LOCATION (City, town, or county) (State) <b>QUEEN ANNE CO., MD.</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 14 1953</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams</b>	25. FUNERAL DIRECTOR ADDRESS <b>BARTON BROS. CENTERVILLE, MD.</b>			

1987 23

1987 23



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

J-520  
53 7298

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7298

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Florence Jones*

2. DATE  
OF  
DEATH

*Aug 13, 1953*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

*Med. Dept.*

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

*JOHNS HOPKINS HOSPITAL*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

*1309 N. Patterson Park Ave*

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months Days  
If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Housewife*

10B. KIND OF BUSINESS OR INDUSTRY

*Own Home*

11. BIRTHPLACE (State or foreign country)

*Philadelphia, Penna.*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*Samuel G. Smith*

14. MOTHER'S MAIDEN NAME

*Florence V. Irvin*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*JOHNS HOPKINS HOSPITAL*

18. *420.0*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUPLICATE

*Cardiac Failure*

INTERVAL BETWEEN ONSET AND DEATH

*2 wk.*

ANTECEDENT CAUSES

(B)

DUPLICATE

*Arteriosclerotic Heart Disease*

*?*

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *8-9-*, 19*53*, to *8-13-*, 19*53*, that I last saw the deceased alive on *8-13-*, 19*53*, and that death occurred at *11:50 a.m.* from the causes and on the date stated above.

23A. SIGNATURE

*Lawrence L. Uhl*

23B. ADDRESS

*JOHNS HOPKINS HOSPITAL*

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Removal*

24B. DATE

*8/15/53*

24C. NAME OF CEMETERY OR CREMATORY

*St. Martin's Cemetery*

24D. LOCATION (City, town, or county)

*Philadelphia, Penna.*

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Huntington Williams, M.D.*

25. FUNERAL DIRECTOR

*St. M. Cook, Inc., 1217 St. Paul St.*

ADDRESS

ENT

CCNUGISE

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1917



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7299

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

53 7299  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mr. Howard F. Lay (Laye)

2. DATE  
OF  
DEATH

Aug. 13, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Mercy Hospital, Inc.

C. CITY OR TOWN (If outside corporate limits, write R.R. and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4120 Moravia Avenue

E. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

July 1, 1895

9. AGE (In years  
last birthday)

58

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Produce Self-Employed

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

August Lay (Laye)

14. MOTHER'S MAIDEN NAME

Elizabeth Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Agnes Lay 4120 Moravia Avenue

18.

260X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

DUE TO

(A) *Anterior subarachnoid hemorrhage* *over 5 yrs.*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B) *Anterior subarachnoid hemorrhage* *over 5 yrs.*(C) *Diabetes Mellitus* *10 yrs.*INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

7/3/53

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED*Diabetes mellitus* *right foot*IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *7/21*, 1953 to *8/13*, 1953 that I last saw the  
deceased alive on *8/12*, 1953 and that death occurred at *2:18 PM*, from the causes and on the date stated above.

23A. SIGNATURE

*W. H. Harris*

M. O.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 17, 1953

24C. NAME OF CEMETERY OR CREMATORY

Western Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

AUG 14 1953

REGISTRAR'S SIGNATURE

*Huntington Williams*

FURNERAL DIRECTOR

Leonard J. Ruck, 5305 Harford Road

ADDRESS

A 66221

(7)

F-325

BALTIMORE CITY HEALTH DEPARTMENT  
 CERTIFICATE OF DEATH

Registered No. **53 7300**

**7300**  
 BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Mrs. MARY FITZMORRIS</b>		2. DATE OF DEATH <b>8-13-53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>JENKINS MEMORIAL HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write full name of township) <b>BALTIMORE</b>	
C. Length of stay in Baltimore <b>69</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>2422 ELAMONT ST. BALTIMORE #16</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>7-13-1884</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>69</b> If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FARREL - (Thomas F.)</b>		14. MOTHER'S MAIDEN NAME <b>Bessie McMormick</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Helen C. Farrell</b>		ADDRESS <b>633 E. 33rd. St.,</b>	

18. <b>331X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <b>CONGESTIVE HEART FAILURE</b> DUE TO <b>CEREBROVASCULAR ACCIDENT</b> (B) <b>SENILE ARTERIOSCLEROSIS</b> DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>6 years</b>
---	--	---

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>4-15-1953</b> , to <b>8-12-1953</b> , that I last saw the deceased alive on <b>8-12-1953</b> , and that death occurred at <b>8-13-53</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Dr. Wilhelm Barmann</b>		23B. ADDRESS <b>St. Agnes Hospital Balto</b>		23C. DATE SIGNED <b>8-13-53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-17-1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Natl. Cem.</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		25. FUNERAL DIRECTOR <b>G. Howard Strong</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 14 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>		ADDRESS <b>3207 W. North Ave.,</b>	

MEDICAL CERTIFICATION

1300-23

1300

Postage paid

(Thomas S.)

Wm. C. Powell & Co. New York, N.Y.

Home

NO

1000 - 1000 - 1000

1000 - 1000 - 1000

1881

Mr. Parker

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7301

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Thomas Anthitz*

2. DATE  
OF  
DEATH

*Aug. 12 1953*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

*Balto Md.*

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

A. STATE

B. COUNTY

*Balto. Md.*

5. FULL NAME OF (If not in hospital or institution, give street address or location)

*1139 Hull St.*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

*Balto. Md. 4-01*

D. STREET ADDRESS (If rural, give location)

*1139 Hull St.*

6. Length of stay in Baltimore

*Life*

Yrs.  
Mos.  
Days

7. SEX

*M*

8. COLOR OR RACE

*W*

9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Married*

10. DATE OF BIRTH

*Feb. 2 1877*

11. AGE (in years last birthday)

*76 years*

12. Under 1 Year

Months; Days

13. Under 24 Hours

Hours; Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*H & O Railroad*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*U. S. A.*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*John Anthitz*

14. MOTHER'S MAIDEN NAME

*Kunde*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*No*

16. SOCIAL SECURITY NO.

17. INFORMANT

*Mr. Anthitz*

ADDRESS

*1139 Hull St.*

18. *177x*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *Carcinoma of prostate with general metastases*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

*Prostatectomy*

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

*Carcinoma of prostate*

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *6/12/*, 1953 to *8/12/53*, 19*53*, that I last saw the deceased alive on *8/12/*, 1953, and that death occurred at *7 P.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Harry Deibel*

23B. ADDRESS

*1226 Hanover St.*

23C. DATE SIGNED

*8/14/53.*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*8/14/53*

24C. NAME OF CEMETERY OR CREMATORY

*Holy Cross Cem*

24D. LOCATION (City, town, or county)

*Brooklyn Md.*

DATE RECEIVED BY

*AUG 17 1953*

REGISTRAR'S SIGNATURE

*Huntington Williams*

25. FUNERAL DIRECTOR

*Chas. F. Dill*

ADDRESS

*1501 E.*

1985

1985



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7302

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered 53 7302

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)*Adelaide Neubauer*2. DATE  
OF  
DEATH*Aug. 12/1953*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

*Balto Md.*

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

*Balto Md.*

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR  
INSTITUTION*1420 Towson St.*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Balto Md 24-01*

D. STREET ADDRESS (If rural, give location)

*1420 Lawson St.*

C. Length of stay in Baltimore

*70 years*Yrs.  
Mos.  
Days

5. SEX

*F.*

6. COLOR OR RACE

*W*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)*Married*

8. DATE OF BIRTH

*Dec. 18/1876*9. AGE (In years  
last birthday)*83*

If Under 1 Year

If Under 24 Hours

Months Days

Hours Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life even if retired)*Housewife*10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

*Lucas Dreyer*

14. MOTHER'S MAIDEN NAME

*Elizabeth Dreyer*15. WAS DECEASED EVER IN U. S. ARMED FORCES  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

*George Neubauer*18. *422.1*DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

CAUSE OF DEATH

*Myocardial Insufficiency*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

*Atherosclerosis -*(C) DUE TO *Myocarditis*INTERVAL BETWEEN  
ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *July 20*, 19*53*, to *Aug 12*, 19*53*, that I last saw the  
deceased alive on *8/11*, 19*53*, and that death occurred at *4:50* a.m., from the causes and on the date stated above.

23A. SIGNATURE

*John G. Scheurech*

23B. ADDRESS

*1337 S. Charles St.*

M. D.

23C. DATE SIGNED

*8/14/53*24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)*Burial*

24B. DATE

*8/15/53*

24C. NAME OF CEMETERY OR CREMATORY

*Holy Cross Cemetery*

24D. LOCATION (City, town, or county)

*Brooklyn Md.*

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR*AUG 14 1953*

REGISTRAR'S SIGNATURE

*Huntington Williams*

25. FUNERAL DIRECTOR

*Chas. F. Bell*

ADDRESS

*1501 E.**Fort Ave.*

1905

23

1905

Lowson

1905

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A-450

53 7303

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

53 7303  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John L. Allan

2. DATE  
OF  
DEATH

Aug. 14, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

2524 East Federal St.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

8-02

D. STREET ADDRESS (if rural, give location)

2524 East Federal Street #13

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Jan. 8, 1874

9. AGE (in years  
last birthday)

79

10. Under 1 Year

11. Under 24 Hours

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Insurance Salesman

10B. KIND OF BUSINESS OR  
INDUSTRY

Self Employed

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Charles Allan

14. MOTHER'S MAIDEN NAME

Elizabeth H. Jenkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

B. Wilson Allan - 2524 E. Federal St.

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Coronary occlusion  
DUE TO Arteriosclerosis

3 Mos  
3 yrs

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)  
DUE TO  
(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Chronic Arthritis

5 yrs

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 15, 1953 to Aug 14, 1953 that I last saw the  
deceased alive on Aug. 13, 1953, and that death occurred at 3:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Elmer S. Singmaster, M. O.

23B. ADDRESS

1613 E. North Ave

23C. DATE SIGNED

8-14-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8-17-53

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cem.

24D. LOCATION (City, town, or county)

North Ave. - Balto. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

John C. Miller Inc. - 2431 E. Cliver St

AUG 15 1953



E 520  
53 7304BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7304

Registered No. \_\_\_\_\_

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Harry S. Ennis</i>		2. DATE OF DEATH <i>Aug 12 1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, or institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>1002</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>			
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>1232 E. Monument St.</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Aug 3 1882</i>	9. AGE (In years last birthday) <i>71</i>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tailor</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Theatre</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>George Ennis</i>			
14. MOTHER'S MAIDEN NAME <i>Maria</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			
16. SOCIAL SECURITY NO. <i>216-07-1658</i>		17. INFORMANT <i>Monica Ennis</i> ADDRESS <i>1232 E. Monument St.</i>			
18. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>hypertensive CARDIO-RENAL disease.</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>		(A) DUE TO (B) DUE TO (C) DUE TO			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. [vascular accident]		CERTIFICATION APPROVED BY <i>Joseph A. Jachimczyk M.D.</i> CHIEF OF ASST. MEDICAL STAFF			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		21. DATE OF OPERATION <i>8/15/53</i>			
22. MAJOR FINDINGS OF OPERATION		23. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
27. TIME (Month) (Day) (Year) (Hour) INJURY		28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		29. HOW DID INJURY OCCUR?	
30. I hereby certify that I attended the deceased from <i>11/19/51</i> to <i>8/12/53</i> that I last saw the deceased alive on <i>7/17/53</i> and that death occurred at <i>4:15 P.</i> from the causes and on the date stated above.					
31. SIGNATURE <i>Rayner</i>		32. ADDRESS <i>1002 E. Madison St. Baltimore, Md.</i>		33. DATE SIGNED <i>8-13-53</i>	
34. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		35. DATE <i>8/15/53</i>		36. NAME OF CEMETERY OR CREMATORY <i>Arcturus Memorial Park</i>	
37. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>		38. DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 15 1953</i>		39. REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i>	
40. FUNERAL DIRECTOR <i>1216 E. Caroline St.</i>		41. ADDRESS <i>1216 E. Caroline St.</i>		42. SIGNATURE <i>770 817</i>	

To be approved  
by medical  
examiner



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				53 7305 Registered No.	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>ANDREW L. SCHMIDT</b>				2. DATE OF DEATH <b>August 13, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF (not in hospital or institution, give street address or location) <b>South Baltimore General Hospital</b>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore <b>Life</b>				D. STREET ADDRESS (If rural, give location) <b>1260 Glyndon Avenue</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>June 12, 1919</b>	9. AGE (In years last birthday) <b>34</b>	If Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Revere Brass &amp;</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>
13. FATHER'S NAME <b>William Schmidt</b>			14. MOTHER'S MAIDEN NAME <b>Helen Adams Schmidt</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>412 10 6756</b>		
			17. INFORMANT ADDRESS <b>William Schmidt, 1260 Glyndon Ave</b>		
18. <b>E 976x</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Shotgun wound of abdomen</b> (A) DUE TO					INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES (B) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>August 8, 1953</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>1260 Linden Avenue</b>	
21D. TIME (Month) (Day) (Year) (Hour) <b>August 8, 1953</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Shot self in abdomen</b>	
22. I certify that I took charge of the remains described above, held an <b>Inspection &amp; Inquiry</b> thereon and from <b>Autopsy, Inspection or Inquiry</b> the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , <b>suicide</b> <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <i>William Schmidt</i>		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <b>August 13, 1953</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 17/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore 29, Md.</b>		24E. FUNERAL DIRECTOR <i>William Schmidt</i>		24F. ADDRESS <b>4101 Edmondson Ave.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 15 1953</b>					
REGISTRAR'S SIGNATURE <i>Huntington Williams</i>					
VS 151 <b>N 879.4</b> <b>N-868.4</b> <b>6903E</b>					

MEDICAL CERTIFICATION

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

53 7306  
Registered No. \_\_\_\_\_

**F 420**  
**53 7306** 53-19147  
BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Ellis, Baby Girl</b>		2. DATE OF DEATH <b>August 15, 1953</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph's Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore		d. STREET ADDRESS (If rural, give location) <b>6600 Eastern Parkway</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>August 14, 1953</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>child</b>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>Lewis Bernard Ellis</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy Naomi Duvall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Father-</b>		ADDRESS <b>SAME</b>	

18. <b>762.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Atelectasis, lungs, bilateral</b>		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
(B) DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>August 14, 1953</b> , to <b>August 14, 1953</b> , that I last saw the deceased alive on <b>August 14, 1953</b> , and that death occurred at <b>8:45 a.m.</b> , from the causes and on the date stated above.					
23a. SIGNATURE <b>Joseph A. Knell, Jr. M.D.</b>		23b. ADDRESS <b>1100 N. Caroline Street</b>		23c. DATE SIGNED <b>August 14, 1953</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Aug. 15-1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	
24d. LOCATION (City, town, or county) (State) <b>BALTO MD</b>		25. FUNERAL DIRECTOR <b>Huntington Williams, 5305 Maryland Rd</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 15 1953</b>		VS 150			

MEDICAL CERTIFICATION



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

J-520  
53 7307

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7307

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mr. Charles Nelson Jones

2. DATE OF DEATH Aug. 15, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4808 Loch Raven Blvd

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

5. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)  
4808 Loch Raven Blvd.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
married

8. DATE OF BIRTH

Nov. 10, 1886

9. AGE (In years last birthday) Months Days Hours Min.

66

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SeaFood

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Thomas Jones

14. MOTHER'S MAIDEN NAME

Rhoda ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Irene H. Jones, 4808 Loch Raven

18. 394X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?  
YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1953 to 8/15, 1953, that I last saw the deceased alive on 7/14, 1953 and that death occurred at 12 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

Aug. 18, 1953

Loudon Park Cem.

Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 15 1953

Huntington Williams, M.D.

Leonard J. Ruck, 5305 Harford Road

Inflammation of labyrinth  
system



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-530  
7308

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7308

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ARTHUR E. GANDY

2. DATE  
OF  
DEATH

AUG. 13, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

518 HARWOOD AVE.

C. CITY OR TOWN (If outside corporate limits, give LOCAL and give township)

MD.  
BALTO

27-48

D. STREET ADDRESS (If rural, give location)

518 HARWOOD AVE.

c. Length of stay in Baltimore

25 YRS.

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

APRIL 24, 1876

9. AGE (in years  
last birthday)

77

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

LUBRICATION ENGINEER PETROLEUM

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

MICHIGAN

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

GANDY

14. MOTHER'S MAIDEN NAME

ELIZABETH KENWRIGHT

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

MRS. KATHLEEN SHILOH

ADDRESS

ABOVE

18. 420.0 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

Arteriosclerotic heart disease

7 yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Generalized arteriosclerosis

7 yrs

DUE TO

(C)

Senility

7 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)

None

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 13<sup>th</sup> 1953, to —, 19—, that I last saw the  
deceased alive on Aug 13<sup>th</sup> 1953, and that death occurred at 3<sup>30</sup> p.m., from the causes and on the date stated above.

23A. SIGNATURE

J.S. Chaffant

23B. ADDRESS

6210 York Road

23C. DATE SIGNED

Aug 3<sup>rd</sup> 53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

8-17-1953

24C. NAME OF CEMETERY OR CREMATORY

DRUID RIDGE

24D. LOCATION (City, town, or county)

PIKESVILLE

MO.

DATE RECEIVED BY  
LOCAL REGISTRAR

AUG 15 1953

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

H.W. JENKINS & SONS CO. 4905 YORK RD.

ADDRESS



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-510 53 7309		CERTIFICATE CORRECTED 8-21-53		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 53 7309	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) GORDON T. SCHWAB (Schwamb)				2. DATE OF DEATH Aug. 14, 1953			
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION 542 Winston Avenue				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location) 542 Winston Avenue							
c. Length of stay in Baltimore Life Yrs. Mos. Days							
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH Dec 11 1902		9. AGE (In years last birthday) 50	If Under 1 Year Months Days	If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Schwamb				14. MOTHER'S MAIDEN NAME Delia McGuire			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes WWI		16. SOCIAL SECURITY NO. 216-01-2971		17. INFORMANT Ethel M. Schwamb		ADDRESS Same	
18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary artery disease with occlusion of right coronary artery Antecedent causes Cardiac hypertrophy and dilatation Pulmonary Edema Chronic passive hyperemia of liver				INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
23A. SIGNATURE Joseph A. Jachimczyk M.D.				23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED 8-14-53	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE Aug 18 1953		24C. NAME OF CEMETERY OR CREMATORY Woodlawn		24D. LOCATION (City, town, or county) (State) Woodlawn Md	
DATE RECEIVED BY LOCAL REGISTRY AUG 15 1953		REGISTRAR'S SIGNATURE Huntington Williams, M.D.		25. FUNERAL DIRECTOR Franklin's Sons		ADDRESS 490 York Rd	

0005 86

0005 86

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

L-300

53 7310

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

53 7310

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Walter H/Lloyd

2. DATE  
OF  
DEATH

August 12, 53

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, City

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)A. STATE  
MarylandB. FULL NAME OF (If not in hospital or institution, give street address or  
location)

507 S.Green Street

C. CITY OR TOWN (If outside corporate limits, write (Rural) and give  
township)

Baltimore, City

D. STREET ADDRESS (If rural, give location)

507 S.Green Street

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

2/24/1900

9. AGE (In years  
last birthday)

53

10. Under 1 Year  
Months Days11. Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William H.Lloyd

14. MOTHER'S MAIDEN NAME

Elizabeth Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Walter Gray-638 W.Conway Street

18. 151X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐NOT WHILE ☐

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-15, 1952, to 8-12, 1953, that I last saw the  
deceased alive on 8-12, 1953, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8/16/53

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary Cemetery

24D. LOCATION (City, town, or county) (State)

A.A.Co., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 15 1953

Huntington Halliwell, M.D.

Specialist

Brounson

VS 150

97099

108 W. Montgomery Street

012X

88

012X

88



A-565

53 7311

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7311  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>John J. AMRHEIM AMRHEIN</b>		2. DATE OF DEATH <b>8/13/53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Mercy Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTL.</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>MERCY HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTL. 27-05</b>	
D. STREET ADDRESS (If rural, give location) <b>3809 Fleetwood Ave.</b>		E. LENGTH OF STAY IN BALTIMORE <b>7</b> Yrs. Mos. Days	
5. SEX <b>M</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>SEPT 11 1900</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GLRATOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MACHINIST</b>	9. AGE (In years, last birthday) <b>52</b>
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH AMRHEIN.</b>		14. MOTHER'S MAIDEN NAME <b>Lena WOLFE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-03-6533</b>	
17. INFORMANT <b>MARGARET E AMRHEIN</b>		ADDRESS <b>3809 FLEETWOOD AVE</b>	
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> DUE TO <b>Probable coronary artery disease</b>			INTERVAL BETWEEN ONSET AND DEATH
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT.			
19A. DATE OF OPERATION <b>none</b>		19B. MAJOR FINDINGS OF OPERATION <b>none</b>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>9:00 PM</b> , 19 <b>53</b> to <b>10:05</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>10:05</b> , 19 <b>53</b> and that death occurred at <b>10:05</b> m., from the causes and on the date stated above.			
23A. SIGNATURE <b>Henry Beck M.D.</b>		23B. ADDRESS <b>Mercy Hospital</b>	
23C. DATE SIGNED <b>8/13/53</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>AUG 17 1953</b>	24C. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEMETERY</b>	24D. LOCATION (City, town, or county) (State) <b>TAYLOR AVE MD.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 15 1953</b>		REGISTRAR'S SIGNATURE <b>Thurston Hollister, M.D.</b>	
FUNERAL DIRECTOR <b>Rippel Bros</b>		ADDRESS <b>7110 BELAIR RD.</b>	

5443L



F 263

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7312

BIRTH NO. 53 7312

1. NAME OF DECEASED (Type or Print) <b>Fogarty, Mrs. Frances</b>		2. DATE OF DEATH <b>August 14, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>Church Home and Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 6</b>	
6. LENGTH OF STAY IN BALTIMORE <b>87 yrs.</b>		D. STREET ADDRESS (If rural, give location) <b>952 Rosedale Ave 5300</b>	
7. SEX <b>Female</b>	8. COLOR OR RACE <b>White</b>	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	10. DATE OF BIRTH <b>Aug. 30, 1869</b>
11. AGE (in years last birthday) <b>83</b>	12. Under 1 Year Months: Days	13. Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland, USA</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Thomas Rach</b>		14. MOTHER'S MAIDEN NAME <b>Anne Wallace</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Sarah Gordon, Balto. Md.</b>		ADDRESS	

18. <b>537X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral thrombosis</b>	CAUSE OF DEATH (A) <b>Cerebral thrombosis</b> DUE TO	INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>multiple abscesses</b>	(B) <b>multiple abscesses</b> DUE TO	<b>few days</b>
(C) <b>Senility</b> DUE TO		<b>long time</b>

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION <b>Aug 11, 1953</b>	19B. MAJOR FINDINGS OF OPERATION <b>Parotid Abscess</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>11 August, 1953</b> , to <b>14 August, 1953</b> that I last saw the deceased alive on <b>8/14</b> 1953, and that death occurred at <b>11:45</b> p.m., from the causes and on the date stated above.		
23A. SIGNATURE <b>Ronald S. Seaton</b> M.D.	23B. ADDRESS <b>Church Home &amp; Hosp.</b>	23C. DATE SIGNED <b>15 Aug. '53</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Aug 18/1953</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>
24D. LOCATION (City, town, or county) (State) <b>Balto Md.</b>	25. FUNERAL DIRECTOR <b>Wm. H. Macroe</b>	ADDRESS <b>4204 Edgemood Ave</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 15 1953</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams, Md.</b>	

<p>NAME OF DECEASED</p> <p>John Doe</p>		<p>AGE</p> <p>45</p>	
<p>SEX</p> <p>Male</p>		<p>DATE OF DEATH</p> <p>Jan 15 1915</p>	
<p>PLACE OF DEATH</p> <p>Home</p>		<p>CAUSE OF DEATH</p> <p>Heart failure</p>	
<p>RESIDENCE</p> <p>123 Main St</p>		<p>REPORTED BY</p> <p>Dr. Smith</p>	
<p>DATE OF BIRTH</p> <p>Jan 1 1870</p>		<p>PLACE OF BIRTH</p> <p>USA</p>	
<p>EDUCATION</p> <p>High School</p>		<p>RELIGION</p> <p>Protestant</p>	
<p>OCCUPATION</p> <p>Teacher</p>		<p>PREVIOUS ILLNESS</p> <p>None</p>	
<p>DATE OF INTERMENT</p> <p>Jan 17 1915</p>		<p>PLACE OF INTERMENT</p> <p>Cemetery</p>	
<p>NAME OF FUNERAL HOME</p> <p>ABC Funeral Home</p>		<p>NAME OF MINISTER</p> <p>Rev. Jones</p>	
<p>NAME OF SURVIVORS</p> <p>Wife and children</p>		<p>NAME OF WITNESSES</p> <p>Dr. Smith, Mr. Brown</p>	
<p>NAME OF CORONER</p> <p>Mr. White</p>		<p>NAME OF JURY</p> <p>None</p>	
<p>NAME OF JUDGE</p> <p>Mr. Black</p>		<p>NAME OF CLERK</p> <p>Mr. Green</p>	

B-620  
53 7313BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7313

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)BRISCOE, ~~XXX~~. HENRIETTA E.2. DATE  
OF  
DEATH

AUG. 13, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

BALTIMORE

MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

ST. AGNES HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE, MD. 20-03

D. STREET ADDRESS (If rural, give location)

403 ROSECROFT TERRACE

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)~~XXXXXXXX~~ Single

B. DATE OF BIRTH

March 16, 1882

9. AGE (In years  
last birthday)

71

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Ret. Auditor Sup.

10B. KIND OF BUSINESS OR  
INDUSTRY

Custom House

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

x Alexander Briscoe

14. MOTHER'S MAIDEN NAME

x Alviare Toland

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

-----

17. INFORMANT

ADDRESS

Miss Alexina Briscoe 403 Rosecroft

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) CEREBRO VASCULAR ACCIDENT

4 days

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) ARTERIOSCLEROTIC HYPERTENSIVE  
CARDIOVASCULAR DISEASE

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 10, 1953 to Aug 13, 1953, that I last saw the  
deceased alive on Aug 13, 1953, and that death occurred at 4:45 P. M., from the causes and on the date stated above.

23A. SIGNATURE

James E. Rowe Jr.

M. D.

23B. ADDRESS

St Agnes Hosp.

23C. DATE SIGNED

8/13/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 17-53

24C. NAME OF CEMETERY OR CREMATORY

Cathedral Cem.

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

AUG 15 1953 Huntington Williams, Md.

25. FUNERAL DIRECTOR

ADDRESS

7 George A. Farley Catonsville, Md.

SEP 80

SEP 80

WALLEY

CONGRESS

SECOND

USA



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-430 FVJ 172899 BIRTH NO. 7314		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 53 7314	
1. NAME OF DECEASED (Type or Print) <b>Charles Bullitt</b>			2. DATE OF DEATH <b>8-12-1953</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore <b>40 yrs.</b>			D. STREET ADDRESS (If rural, give location) <b>721 West Lanvale Street #17</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>April 9, 1880</b>	9. AGE (In years last birthday) <b>73</b>	H Under 1 Year Months: Days H Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME <b>Catherine</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>B.C.H. 4940 Eastern Ave. (records)</b>		
18. <b>023X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, nsthenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b> DUE TO ANTECEDENT CAUSES <b>L. uetic Cardio Vascular Disease</b> DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>7</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7 - 30 - 1953</b> , to <b>8 - 12 - 1953</b> that I last saw the deceased alive on <b>8 - 12 - 1953</b> , and that death occurred at <b>1:55 P.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <i>H. John V. ...</i>		23B. ADDRESS <b>4940 Eastern Avenue</b>		23C. DATE SIGNED <b>8-12-1953</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/17/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		25. FUNERAL DIRECTOR ADDRESS <b>Artlington St. Phillips 1808 N.</b>			
DATE RECEIVED BY REGISTRAR'S SIGNATURE <b>AUG 19 1953</b>					
VS 150 <b>5906 E</b> <b>Monroe St.</b>					

MIT 28

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

NOV 15 1944

OFFICE OF THE DIRECTOR

THE BUREAU OF THE ARMY

WASHINGTON

NOV 15 1944

OFFICE OF THE DIRECTOR

WASHINGTON

THE BUREAU OF THE ARMY

WASHINGTON

NOV 15 1944

THE BUREAU OF THE ARMY

MIT 28

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 53 7315

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)Leland J. McMillian2. DATE OF DEATH  
AUG 13 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Med. Opler 6

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION  
JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 5-01

D. STREET ADDRESS (If rural, give location)

800 E Baltimore St.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

9-9-01

9. AGE (In years last birthday)

51

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

OILER - SEAMAN

10B. KIND OF BUSINESS OR INDUSTRY

U.S. COAST GUARD

11. BIRTHPLACE (State or foreign country)

CHARLESTON, S. C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

THOMAS J. McMILLIAN

14. MOTHER'S MAIDEN NAME

SUSAN ANDREWS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

-

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

276-03-8299

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18. 581.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Bleeding esophageal varices

DUE TO

25 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Laennec's Cirrhosis

DUE TO

(C) Chronic alcoholism

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

none

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-3- 1953 to 8-13- 1953, that I last saw the deceased alive on 8-13- 1953, and that death occurred at 2 P m., from the causes and on the date stated above.

23A. SIGNATURE

Edward L. Alexander Jr.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

13 August 1953

24A. BURIAL, CREMATION, REMOVAL (Specify)

CREMATION

24B. DATE

8/15/53

24C. NAME OF CEMETERY OR CREMATORY

GREEN MOUNT

24D. LOCATION (City, town, or county) (State)

BALTIMORE, MARYLAND

DATE RECEIVED BY LOCAL REGISTRAR

AUG 15 1953

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wm. C. C. & Co., Inc.

ADDRESS

1217 ST. PAUL ST.

*[Faint, illegible text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]*

S-362  
53 7316

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7316  
Registered No.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
GEORGE STURGEON		8-12-53	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE Maryland	
b. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE South Baltimore General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore (13)	
d. Length of stay in Baltimore Yrs. Mos. Days		e. STREET ADDRESS (If rural, give location) 2028 E. North Ave.	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 9/6/55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 97
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James H. Sturgeon		14. MOTHER'S MAIDEN NAME Anne Hochheide	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknowns) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Emma Kraisser (Daughter)		ADDRESS 2028 E. North Ave.	

18. 610X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) Uremia		DUE TO			
(B) Urinary Retention		DUE TO			
(C) Senile Prostatic Hypertrophy		DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Arteriosclerotic Heart Disease.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from AUG. 1, 1953, to AUG. 12, 1953, that I last saw the deceased alive on AUG. 12, 1953, and that death occurred at 5:15 a.m., from the causes and on the date stated above.					
23a. SIGNATURE Arnoldo Benito Jimenez		23b. ADDRESS		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug. 15, 1953		24c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.	
24d. LOCATION (City, town, or county) Baltimore Md.		24e. NAME OF CEMETERY OR CREMATORY Baltimore Md.		24f. LOCATION (City, town, or county) Baltimore Md.	
DATE RECEIVED BY LOCAL REGISTRAR AUG 15 1953		REGISTRAR'S SIGNATURE Huntington Williams, M.D.		25. FUNERAL DIRECTOR HENRY SANDER & SONS, INC. Baltimore Md.	
VS 150				ADDRESS [Signature]	

MEDICAL CERTIFICATION

0157

82

UNITED STATES OF AMERICA

0157

CERTIFICATE OF MARRIAGE

1912





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. **53 7317**

BIRTH NO. **731753-20063**

1. NAME OF DECEASED  
(Type or Print) **Asa Maurice Coleman**

2. DATE  
OF  
DEATH **Aug 14, 1953**

3. PLACE OF DEATH:

A. Baltimore City, Maryland **11th - O.P. Dept**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE **md**

B. COUNTY **9-09**

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION **JOHNS HOPKINS HOSPITAL**

C. CITY OR TOWN **Baltimore**

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location) **1313 Annapolis St**

C. Length of stay in Baltimore **Life**

Yrs.  
Mos.  
Days

5. SEX **Male**

6. COLOR OR RACE **Colored**

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify) **Infant**

8. DATE OF BIRTH **Aug 10 53**

9. AGE (In years  
last birthday) **4**

If Under 1 Year  
Months: Days: **4**

If Under 24 Hours  
Hours: Min. **4**

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired) **none**

10B. KIND OF BUSINESS OR  
INDUSTRY **none**

11. BIRTHPLACE (State or foreign country) **md.**

12. CITIZEN OF  
WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Asa Coleman**

14. MOTHER'S MAIDEN NAME **Adele Knox**

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) **No**

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO. **none**

17. INFORMANT **JOHNS HOPKINS HOSPITAL**

ADDRESS

18. **768.0**

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) **? Septicemia**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONITION CAUSING IT.

19A. DATE OF OPERATION **8-14-53**

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?  
YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ WORK ☒ NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **8-14-**, 19**53**, **8-14-**, 19**53** that I last saw the  
deceased alive on **8-14-**, 19**53**, and that death occurred at **11:00** m., from the causes and on the date stated above.

23A. SIGNATURE **P. Doyle**

**JOHNS HOPKINS HOSPITAL**

23C. DATE SIGNED **Aug 14, 1953**

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify) **Burial**

24B. DATE **8-15-1953**

24C. NAME OF CEMETERY OR CREMATORY **Mt. Calvary Cemetery**

24D. LOCATION (City, town, or county) (State) **Baltimore Co. Md.**

DATE RECEIVED BY  
LOCAL REGISTRAR **AUG 15 1953**

REGISTRAR'S SIGNATURE **Huntington Williams**

25. FUNERAL DIRECTOR **Randolph J. Collick**

ADDRESS **1412 E. Prester**

1957

8

UNITED STATES GOVERNMENT  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

1957

8

1

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

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CONFIDENTIAL

CONFIDENTIAL

53 7318

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

53 7318

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HARRY C. REYNOLDS

2. DATE  
OF  
DEATH

8/16/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Mary Hospital, Inc.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Kent

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Queenstown

Rural

D. STREET ADDRESS (If rural, give location)

6400

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days  
8

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
(WIDOWED, DIVORCED) (Specify)

WIDOWED

8. DATE OF BIRTH

8/21/1882

9. AGE (In years  
last birthday)

70

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.

11

23

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR  
INDUSTRY

Groceries

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

John E. Reynolds

14. MOTHER'S MAIDEN NAME

Ann Elizabeth Rhodes

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown)

No

(If yes, give year or dates of service)

No

16. SOCIAL  
SECURITY NO.

212-07-8545

17. INFORMANT

Harry C. Reynolds Jr. Queenstown, Md.

ADDRESS

18. 151X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Pericarditis of Heart

3 yrs.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

WITH

(B)

Generalized abdominal metastases

6 mos

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Dec 1952

19B. MAJOR FINDINGS OF OPERATION

Generalized Abdominal Carcinoma -

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/8, 1953 to 8/16, 1953 that I last saw the  
deceased alive on 8/15, 1953, and that death occurred at 12:42 A.M., from the causes and on the date stated above.

23A. SIGNATURE

John W. Hume Jr.

M. D.

23B. ADDRESS

Mary Hospital

23C. DATE SIGNED

8/16/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

St. Peter's Cemetery

24D. LOCATION (City, town, or county)

Queenstown, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington, W. Va.

25. FUNERAL DIRECTOR

John D. Williams - Easton, Md.

ADDRESS



B3 454

53 7319

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7319

Registered No.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Joseph Blimline		Aug. 14, 1953	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md.	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
747 <del>374</del> Poplar Grove St.		Baltimore	
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location)	
Life		747 Poplar Grove St.	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
M	W	W	10/27/1873
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Theater		Baltimore	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
Retired		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Abraham Blimline		Annie Allen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
NO			
17. INFORMANT		ADDRESS	
Mrs. Bernard Blimline		2857 W. Lanvale	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease			Years
DUE TO			
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Arteriosclerosis			Years
DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?			
YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from Aug 1, 1947, to Aug 14, 1953 that I last saw the deceased alive on Aug 14, 1953, and that death occurred at 10 A. m., from the causes and on the date stated above.			
23A. SIGNATURE		23B. ADDRESS	
Mendel's		651 N Bentall St	
M. D.		23C. DATE SIGNED	
		8/15/53	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		Aug. 17, 1953	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Louden Park		Baltimore Md.	
DATE RECEIVED BY LOCAL REGISTRAR		25. FUNERAL DIRECTOR	
AUG 16 1953		John T. Stensbury	
REGISTRAR'S SIGNATURE		ADDRESS	
H. J. Stensbury		2700 Edmondson Ave.	





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7320

BIRTH NO.

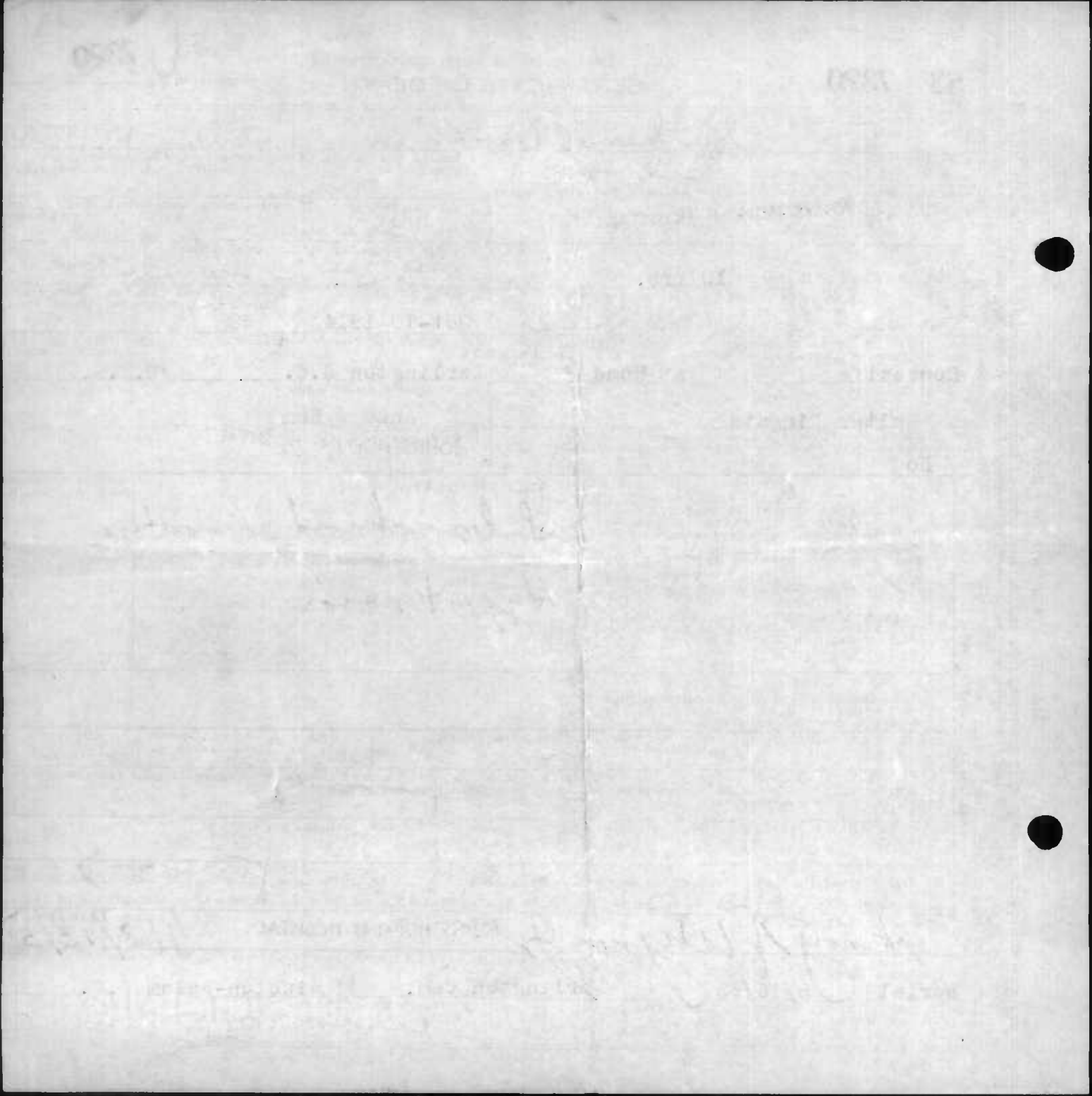
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7320  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Girthera W. Hutchison</i>			2. DATE OF DEATH <i>Aug 13, 1953</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Del 4</i>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>md.</i> B. COUNTY		
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 12-05</i>		
6. Length of stay in Baltimore <i>10 Yrs.</i>			D. STREET ADDRESS (If rural, give location) <i>434 E. Lawrence St.</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Oct-10-1914</i>	9. AGE (In years last birthday) <i>38</i>	10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		
11. BIRTHPLACE (State or foreign country) <i>Darlington S.C.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Walter Wingate</i>			14. MOTHER'S MAIDEN NAME <i>Anna Ham</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		
17. INFORMATION			ADDRESS		

18. <i>330X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Subarachnoid hemorrhage</i>		CAUSE OF DEATH <i>Hypertension</i>	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO (A) <i>Subarachnoid hemorrhage</i> (B) <i>Hypertension</i> (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION <i>8/17</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>8/7</i> , 19 <i>53</i> to <i>8/13</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>8/13</i> , 19 <i>53</i> and that death occurred at <i>8:10 P.m.</i> , from the causes and on the date stated above.							
23A. SIGNATURE <i>Henry F. Wagner Jr.</i>				23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>8/13/53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/16/53</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Darlington Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Winston-Salem N.C.</i>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>Huntington W. ...</i>		25. FUNERAL DIRECTOR <i>Elroy's Wilson 1000 Bunting</i>		ADDRESS	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7321

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

53 7321

Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		Zillpia Hayes		Aug-14-1953	
3. PLACE OF DEATH:		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
A. Baltimore City, Maryland Balto. City		A. STATE Maryland		B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)			
2005 North Pulaski Street		Baltimore		15-04	
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location)			
3 Mos.		2005 North pulaski Street			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Year Months: Days
Female	Col.	Married	April, 19.93	60	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		At Home		Dillon S.C.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.		Ephran Hayes		Liza Hays	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Amie Gibson 2005 N. Pulaski St	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) DUE TO		Hypertensive Cardio-vascular disease		7	
(B) DUE TO		Hypertension		2	
(C) DUE TO					
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY?	
0				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Aug 14, 1953 to Aug 14, 1953 that I last saw the deceased alive on Aug 14, 1953, and that death occurred at 8:30 P.M., from the causes and on the date stated above.					
23A. SIGNATURE		23B. ADDRESS		23C. DATE SIGNED	
E. Waller Huntington		2301 Harlem Ave		8/15/53	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		8/16/1953		Union Cem.	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS			
Lakeview S.C.		Eliza W. Wilson 1000 Bunting Ave			
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE			
AUG 16 1953		Huntington			
VS 150					

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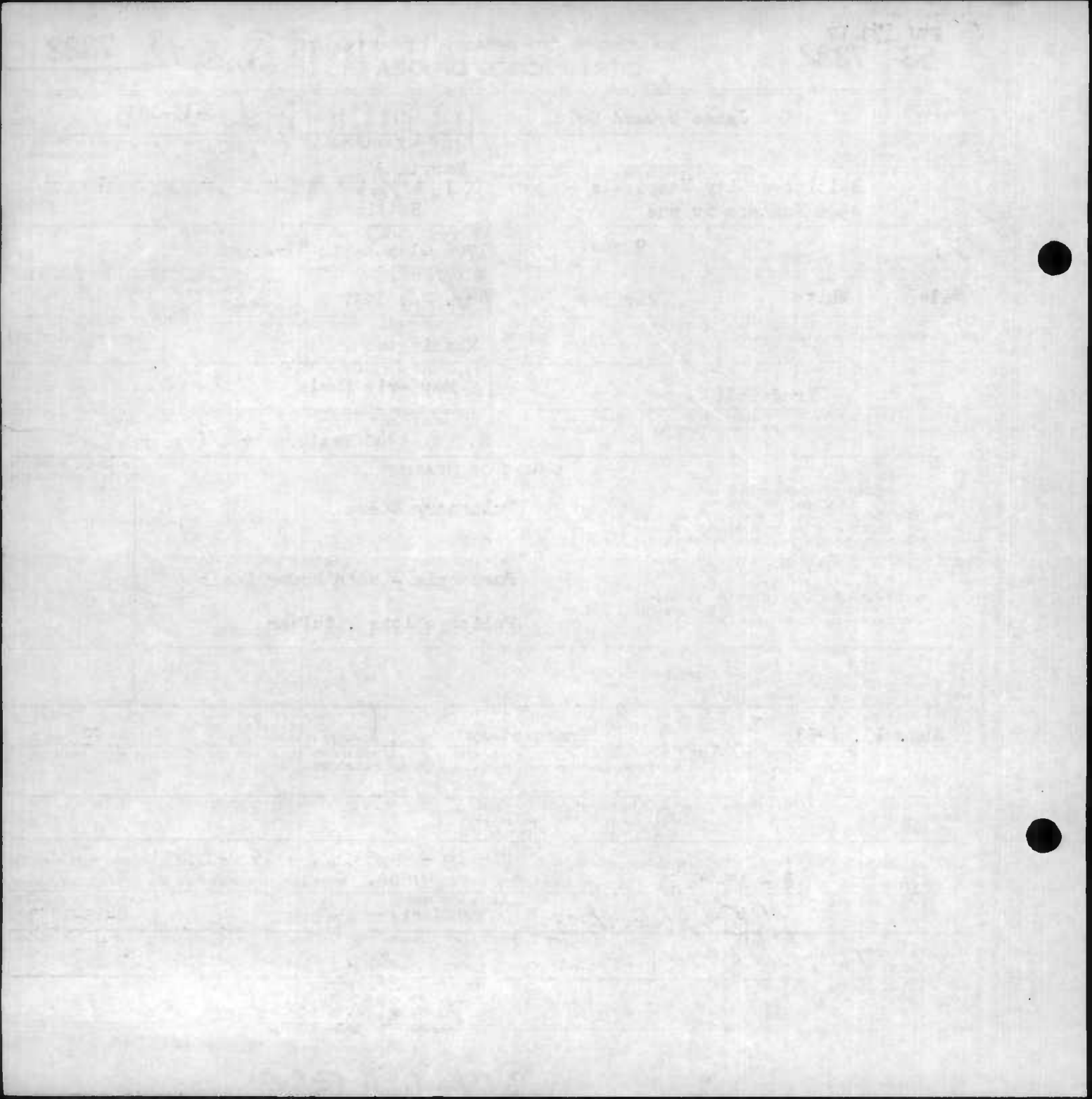
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4-30 RVJ 173417 53 7322		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		53 7322 Registered No.	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>James Howard Holt</b>				2. DATE OF DEATH <b>8-15-1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTO.</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
5. Length of stay in Baltimore <b>31</b> Yrs. <b>9 mos.</b> Mos. Days			D. STREET ADDRESS (If rural, give location) <b>1706 Glen Keith Blvd. #4</b> <b>5355</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Aug. 20, 1927</b>	9. AGE (In years last birthday) <b>26</b>	10 Under 1 Year Months Days 11 Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington</b>	
13. FATHER'S NAME <b>Fred Holt</b>			14. MOTHER'S MAIDEN NAME <b>Marjorie Ennis</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>B.C.H. 4940 Eastern Ave. (records)</b>	
18. <b>080.0</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <b>Pulmonary Edema</b> DUE TO ANTECEDENT CAUSES (B) <b>Pneumonia - both Lower Lobes</b> DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) <b>Polio-myelitis, Bulbar</b>			INTERVAL BETWEEN ONSET AND DEATH ✓		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>Aug. 15, 1953</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Tracheotomy</b>		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>8 - 14 - 1953</b> , to <b>8 - 15 - 1953</b> that I last saw the deceased alive on <b>8 - 15 - 1953</b> , and that death occurred at <b>4:30 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <i>H. C. Jones</i>		23B. ADDRESS <b>4940 Eastern Avenue</b>		23C. DATE SIGNED <b>8-15-1953</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>buried</b>		24B. DATE <b>Aug 17 1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Hyman Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>		24E. LOCATION (City, town, or county) (State) <b>Clinton Co Pa</b>			
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>H. C. Jones</i>		25. FUNERAL DIRECTOR ADDRESS <b>610 York Rd</b>	





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-216  
53 7323BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7323

Registered No. \_\_\_\_\_

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HAZEL NORSE WASHBURN</b>		2. DATE OF DEATH <b>Aug. 14, 1953</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>3111 N. Charles St. Allston Apts. #3B</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>			
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>3111 N. Charles St.</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Nov. 24, 1891</b>	9. AGE (In years last birthday) <b>61</b>	10. Under 1 Year Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Gardner, Mass</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Freeman Morse</b>		14. MOTHER'S MAIDEN NAME <b>Mannie Wilson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT ADDRESS Rd <b>Mr. George M. Glazier 116 St. Dunstons</b>	
18. <b>155X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Caecum of Portal Vein = metastases to liver and adjacent lymph nodes</b>		CAUSE OF DEATH (A) _____ DUE TO _____ (B) _____ DUE TO _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 1/2 Mos</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>May, 1953</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>(A) above</b>		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <b>July 1952</b> to <b>August 14, 1953</b> that I last saw the deceased alive on <b>Aug. 14, 1953</b> , and that death occurred at <b>5:30 p.m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>W. Dreflen Herapferger</b>		23B. ADDRESS <b>214 Medical Arts Building</b>		23C. DATE SIGNED <b>8/15/53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>8/17/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baldwinville, Mass</b>		24E. DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 16 1953</b>		24F. REGISTRAR'S SIGNATURE <b>Huntington Williams</b>	
24G. FUNERAL DIRECTOR <b>Wm. J. Tucker</b>		24H. ADDRESS <b>Box 100 Baltimore Md</b>			

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53 7324

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7324

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

FRANCIS EDWARD YESTADT

2. DATE  
OF  
DEATH

AUGUST 15, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

16 28 CHILTON ST. (18)

C. Length of stay in Baltimore

58

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

10/22/94

9. AGE (In years,  
last birthday)

58

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

SUPERVISOR - BETH. STEEL

10B. KIND OF BUSINESS OR  
INDUSTRY

STEEL

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U. S.

13. FATHER'S NAME

GEORGE YESTADT

14. MOTHER'S MAIDEN NAME

ELIZABETH GOOD

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

WIFE

ADDRESS

SAME AS ABOVE

18. 331X I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) INTRACRANIAL HEMORRHAGE

3 DAYS

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/12, 1953 to 8/15, 1953 that I last saw the  
deceased alive on 8/15, 1953, and that death occurred at 8:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Harry S. Hecker

M. D.

23B. ADDRESS

Mercy Hospital

23C. DATE SIGNED

8/15/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

8. 19. 53

24C. NAME OF CEMETERY OR CREMATORY

LODON PK CEM

24D. LOCATION (City, town, or county) (State)

BALTO MD

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

H. J. Hecker, M.D., J. Hecker, Sec. Inc. Baltimore

25. FUNERAL DIRECTOR

ADDRESS

1954

UNITED STATES DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1954

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Usual residence		7. Date of death		8. Time of death		9. Cause of death		10. Place of death		11. Signature of physician		12. Signature of registrar	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V-635

53 7325

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7325

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Louis Vordenberge (Middle Initial "M")

2. DATE  
OF  
DEATH 8-14-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
location)

St. Agnes Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore 29 20-07

D. STREET ADDRESS (If rural, give location)

508 Allendale St.

5. SEX

male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowdd

8. DATE OF BIRTH

Aug. 19, 1865

9. AGE (In years  
last birthday)

87

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Store - Partner

10B. KIND OF BUSINESS OR  
INDUSTRY

Saddlery - Retail

11. BIRTHPLACE (State or foreign country)

Maryland Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Wm. Vordemberge

14. MOTHER'S MAIDEN NAME

? Nieman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

?

17. INFORMANT

Mr. Howard M. Vordemberge

ADDRESS

816 Madison Ave.

18. 610x

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Renal insufficiency &  
anemia (post op)

2 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Arteriosclerotic cardiovascular

(C) DUE TO

Benign prostatic hypertrophy

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Aug 10, 53

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

Prostatic hypertrophy

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 10, 1953 to Aug 14, 1953 that I last saw the  
deceased alive on Aug 14, 1953 and that death occurred at 8:10 P. M., from the causes and on the date stated above.

23A. SIGNATURE

James E. Rowe Jr.

M. D.

23B. ADDRESS

St Agnes Hospital

23C. DATE SIGNED

8/14/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8/17/53

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cem.

24D. LOCATION (City, town, or county)

Pikesville, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

AUG 18 1953

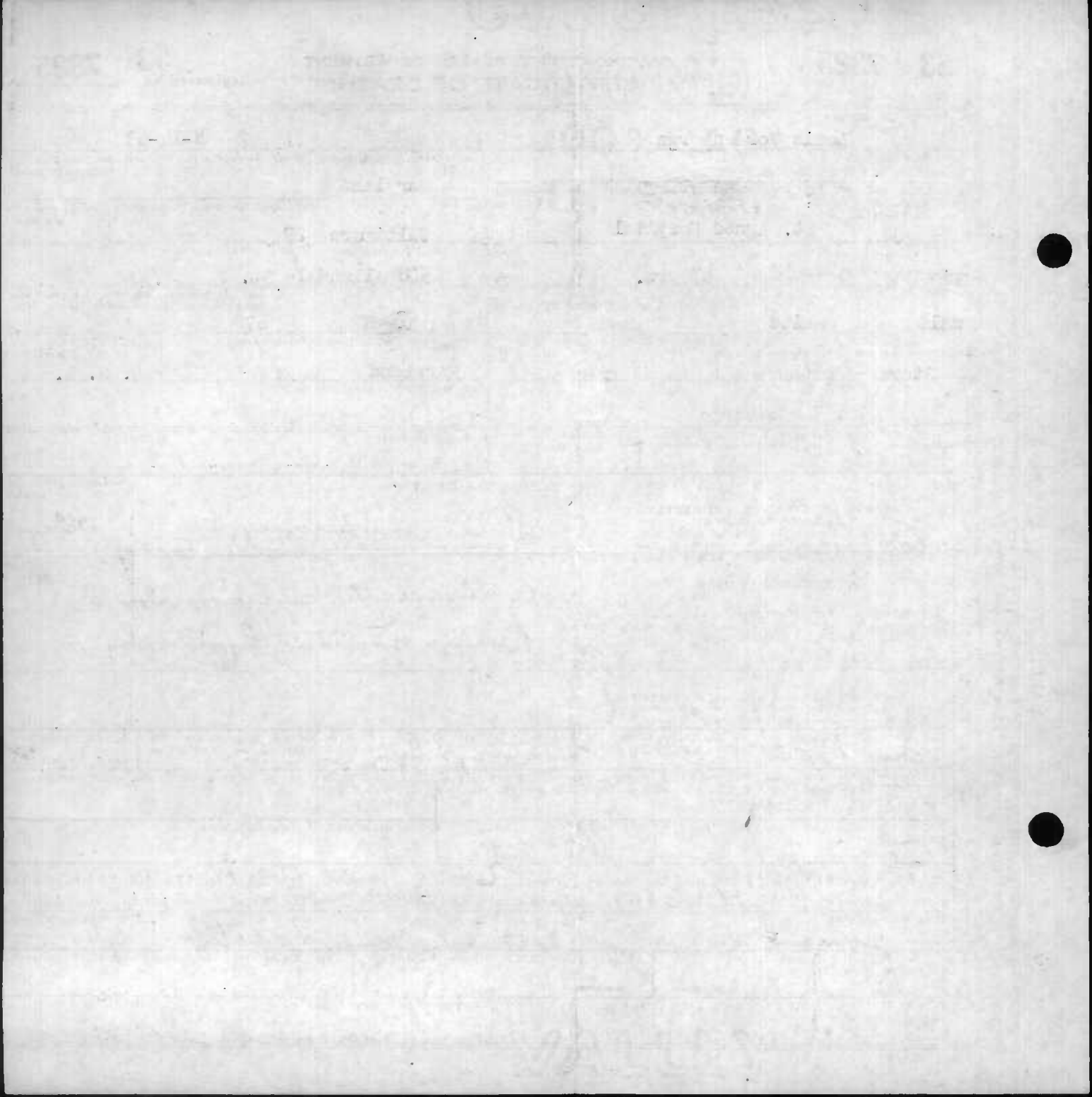
REGISTRAR'S SIGNATURE

Huntington Watson

25. FUNERAL DIRECTOR

Wm. J. Tiekner, Son Inc. Belts Md

ADDRESS





53 7326

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7326

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)*Morris Greenberg*2. DATE  
OF  
DEATH*Aug. 15/53.*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION*4613 Park Heights Ave.*4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
A. STATE B. COUNTY before admission)*Maryland*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore 15-38*

D. STREET ADDRESS (If rural, give location)

*3818 Woodhaven Ave.*

c. Length of stay in Baltimore

*65*Yrs.  
Mos.  
Days

5. SEX

*Male*

6. COLOR OR RACE

*White*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)*Widower*

8. DATE OF BIRTH

*1863*9. AGE (in years  
last birthday)*90*If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)*Tailor*10B. KIND OF BUSINESS OR  
INDUSTRY*Shops.*

11. BIRTHPLACE (State or foreign country)

*Russia*12. CITIZEN OF  
WHAT COUNTRY?*U. S. A.*

13. FATHER'S NAME

*Unknown*

14. MOTHER'S MAIDEN NAME

*Unknown*15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT ADDRESS

*Sal Greenberg - 740 N. North Ave.*18. *331X*

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

*Acute Cerebral Hemorrhage*

ANTECEDENT CAUSES

(B) DUE TO

*General Arteriosclerosis*DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *8/15/53*, 19*53*, to *8/15/53*, that I last saw the  
deceased alive on *8/15*, 19*53* and that death occurred at *750 P.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*A. H. Hornstein*

M. O.

23B. ADDRESS

*204 E. Biddle St*

23C. DATE SIGNED

*8/15/53*24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)*Burial*

24B. DATE

*7/16/53*

24C. NAME OF CEMETERY OR CREMATORY

*City Chain, Wash. Rd.*

24D. LOCATION (City, town, or county) (State)

*Baltimore, Maryland*DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Huntington Williams, Jr.*

25. FUNERAL DIRECTOR

*John J. ... 1124-26 N. North Ave.*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. **53 7327**

BIRTH NO. **53 7327**

1. NAME OF DECEASED (Type or Print) <b>ROSE ROSEMAN</b>		2. DATE OF DEATH <b>AUG. 15, 1953</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Baltimore</b>	
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSP.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 28-02</b>	
c. Length of stay in Baltimore <b>56</b> Yrs. <b>56</b> Mos. <b>56</b> Days		d. STREET ADDRESS (If rural, give location) <b>4407 Liberty Heights</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE MARRIED, <b>WIDOWED</b> DIVORCED (Specify)	8. DATE OF BIRTH <b>1873</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	9. AGE (in years last birthday) <b>80</b>
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>?</b>	
13. FATHER'S NAME <b>Not Known</b>		14. MOTHER'S MAIDEN NAME <b>Blase</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Louis Roseman</b>		ADDRESS <b>same</b>	

18. <b>151X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CA OF STOMACH</b>	INTERVAL BETWEEN ONSET AND DEATH <b>9mo.</b>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) DUE TO</b> <b>(B) DUE TO</b> <b>(C) DUE TO</b>	

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **8/14**, 19**53**, to **8/15**, 19**53**, that I last saw the deceased alive on **8/15**, 19**53**, and that death occurred at **4:30 p.m.**, from the causes and on the date stated above.

23A. SIGNATURE <b>David Golub</b>	23B. ADDRESS <b>Louis Hays</b>	23C. DATE SIGNED <b>8/15/53</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>8-16-53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Hill</b>
24d. LOCATION (City, town, or county) (State) <b>Bethesda Md</b>	25. FUNERAL DIRECTOR <b>Jack Kishine</b> ADDRESS <b>2100 Cretow Rd</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 16 1953</b>		
REGISTRAR'S SIGNATURE <b>Wm. H. Hays</b>		

CERTIFICATE OF DEATH

1937 85

1937

DEPARTMENT OF HEALTH

1937

Name of Deceased		Date of Birth		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		1/1/1900		Male		White		Roman Catholic		Single		Teacher		Heart Disease		Home		10:00 AM		J. Smith		A. Jones	
Address		City		State		County		Zip		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Registration		Time of Registration	
123 Main St		New York		NY		Albany		12245		1/1/1937		10:00 AM		Home		J. Smith		A. Jones		1/1/1937		10:00 AM	
Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar		Date of Registration		Time of Registration		Place of Registration		Signature of Registrar		Date of Registration		Time of Registration		Place of Registration	
Heart Disease		Home		10:00 AM		J. Smith		A. Jones		1/1/1937		10:00 AM		Home		J. Smith		1/1/1937		10:00 AM		Home	

BALTIMORE CITY HEALTH DEPARTMENT

53 7328  
Registered No.

53 7328 49-08968

## CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BARRY ZILBER

2. DATE  
OF  
DEATH

8/14/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

before admission)

MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or  
location)

SINAL HOSPITAL OF BALTIMORE, INC.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

BALTIMORE 27-19

D. STREET ADDRESS (If rural, give location)

5508 Highgate Drive

4. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

S

8. DATE OF BIRTH

3/19/53

9. AGE (In years  
last birthday)

4

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

RAYMOND

14. MOTHER'S MAIDEN NAME

BETTY Freedman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

204/3

5508 HIGHGATE DRIVE

18. 204.0

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) CEREBRAL HEMORRHAGE

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) THROMBOCYTOPENIA

DUE TO

(C) LYMPHATIC LEUCEMIA

2 1/2 yrs.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-12-53 to 8/14/53, 1953 that I last saw the  
deceased alive on 8/14, 1953, and that death occurred at 11A m., from the causes and on the date stated above.

23A. SIGNATURE

G. Robert D. Barker

M. D.

23B. ADDRESS

Sinal Hospital, Baltimore

23C. DATE SIGNED

8/14/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

8-16-53

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Young men

24D. LOCATION (City, town, or county)

Baltimore, Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

FUNERAL DIRECTOR

J. A. Lewis

ADDRESS

2100 Canton Rd

AUG 16 1953





K-656

53 7329

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7329

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Charles Kramer

2. DATE  
OF  
DEATH

Aug 15, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Med Thay 2

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md.

27-19

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 15

D. STREET ADDRESS (If rural, give location)

5721 Narcissus Ave

33  
E. Length of stay in Baltimore

Life Yrs. Mo. Days

5. SEX

Male White

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

6-22-09

9. AGE (In years,  
last birthday)

44

H Under 1 Year

Months: Days

H Under 24 Hours

Hours: Min.

10. USUAL OCCUPATION (Give kind of  
work during most of working life, even if retired)

Pharmacist

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Abraham

14. MOTHER'S MAIDEN NAME

Sarah

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18. 204.2

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Acute monocytic leukemia

INTERVAL BETWEEN  
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-11-1953 to 8-15-1953, that I last saw the  
deceased alive on 8-15-1953 and that death occurred at 10:56 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Norman E. Hoover

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

8-15-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

8-16-53

24C. NAME OF CEMETERY OR CREMATORY

Mt Carmel

24D. LOCATION (City, town, or county).

Balto

(State)

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Jack Reuben 2100 Eutan Rd

ADDRESS



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

R. 200 53 7330 48-21343		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		53 7330 Registered No.	
1. NAME OF DECEASED (Type or Print) <b>Patricia Ann Ranch</b>			2. DATE OF DEATH <b>8/14/53</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTO.</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>University Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
C. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>1819 Summit Ave. (24)</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>10/1/48</b>	9. AGE (In years last birthday) <b>4</b>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Lawrence Ranch</b>			14. MOTHER'S MAIDEN NAME <b>MURIEL Scon</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		
17. INFORMANT <b>Parents</b>			ADDRESS <b>Same</b>		
18. <b>204.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Lymphatic Leukemia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 mos.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) ..... (C) .....					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>Aug. 14, 1953</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		19C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <b>Aug. 3</b> , 19 <b>53</b> to <b>Aug. 14</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>Aug. 14</b> , 19 <b>53</b> , and that death occurred at <b>11:20 A.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Wm. H. Glasman, Jr.</b>		23B. ADDRESS <b>University Hospital</b>		23C. DATE SIGNED <b>8/14/53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>AUG:17:53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEMETERY BALTIMORE MARYLAND</b>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <b>H. F. Wippert &amp; Son</b>		25. FUNERAL DIRECTOR <b>H. F. Wippert &amp; Son</b>	
F.B.WIPPERT & SON 1300 EUTAW PL.					

Murriel =

M-460  
53 7331

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7331  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		JAMES H. MILLER.		Aug 13 1953	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION 4414 Falls Road		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-15			
Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 4414 Falls Road			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Oct 8, 1870	9. AGE (in years, last birthday) 82	If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bricklayer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Samuel L. Miller		14. MOTHER'S MAIDEN NAME Elizabeth C. Belt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Frederick L. Miller - 4414 Falls Rd	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Coronary Occlusion DUE TO (B) Coronary heart disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 10 y.	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from - 1943, to Aug 13, 1953, that I last saw the deceased alive on Aug 12, 1953 and that death occurred at 8 P. m., from the causes and on the date stated above.					
23A. SIGNATURE Edward W. Wallenstein		23B. ADDRESS M. D. 848 W. 36 St.		23C. DATE SIGNED 8-15-53	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug 17/53		24C. NAME OF CEMETERY OR CREMATORY St. Mary's Home	
24D. LOCATION (City, town, or county) (State) 3900 Roland Ave Md.		24E. FUNERAL DIRECTOR Austin E. Donovan		24F. ADDRESS 3818 Roland Ave	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE Thurston		25. FUNERAL DIRECTOR ADDRESS	

MEDICAL CERTIFICATION

MAY

26

RECEIVED BY THE POST OFFICE

1888





B-356  
53 7332

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7332  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JOHN HOWARD BITTNER</b>		2. DATE OF DEATH <b>AUG. 13, 1953.</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2605</b>			
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>DOCTOR'S HOSP.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE</b>			
c. Length of stay in Baltimore <b>LIFE</b>		d. STREET ADDRESS (If rural, give location) <b>505 S. TOLNA ST.</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>FEB. 28, 1917</b>	9. AGE (In years last birthday) <b>35</b>	10. Under 1 Year Months: Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WELDER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BETH STEEL CO</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>CONRAD BITTNER</b>		14. MOTHER'S MAIDEN NAME <b>MARY C. RULEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-03-4371</b>		17. INFORMANT <b>V. VICTORIA BITTNER</b>	
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary thrombosis</b>		CAUSE OF DEATH <b>Coronary thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19a. DATE OF OPERATION <b>0</b>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>6-15-19</b> , to <b>19</b> , that I last saw the deceased alive on <b>6-15-19</b> , and that death occurred at <b>6-15-19</b> m., from the causes and on the date stated above.					
23a. SIGNATURE <b>Harry Gilbert</b>		23b. ADDRESS <b>6000 Eastern av</b>		23c. DATE SIGNED <b>8/16/53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>8-17-53</b>		24c. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS CEM.</b>	
24d. LOCATION (City, town, or county) (State) <b>DUNDALK AVE, BALTO. MD.</b>		24e. DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 16 1953</b>		24f. REGISTRAR'S SIGNATURE <b>Huntington Williams</b>	
24g. FUNERAL DIRECTOR <b>Charles S. Geier</b>		24h. ADDRESS <b>901 S. CONKLING ST. BALTO., MD.</b>		24i. VS 150	

6453U

100

1975-1976

The errors appearing on this certificate, which have been corrected, were placed there by the Melchor Nursing Home. (W.B. Bradley M.B.)

53 7333

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered 53 7333

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARY JANE GIVENS

2. DATE  
OF  
DEATH

AUG 13, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

MD

5. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Melchor Nursing Home -

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE 15-12

7. STREET ADDRESS (If rural, give location)

2330 DRUID PARK DRIVE

8. Length of stay in Baltimore

25 yrs

Yrs.  
Mos.  
Days

5. SEX

FEMALE

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

FEB 21, 1893

9. AGE (In years last birthday)

60

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Penn

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

JAMES GIVENS

HENRY WINSHIP

14. MOTHER'S MAIDEN NAME

MARY WALLWORK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

LEONA KLEIN 1201 LINDA AVE

ADDRESS

18. 170X

212-676383

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

CARCINOMA OF RIGHT  
BREAST WITH METASTASES

UNKNOWN

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) DUE TO  
(C)II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONCOITION CAUSING IT.

19A. DATE OF OPERATION

Dec. 14 1948

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

CARCINOMA RT BREAST

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from AUG 10, 1953, to AUG 13, 1953, that I last saw the deceased alive on AUG 11, 1953, and that death occurred at 9:05 Am., from the causes and on the date stated above.

23A. SIGNATURE

C. B. Cone

23B. ADDRESS

112 W 25th St

23C. DATE SIGNED

Aug 13 1953

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

8-17-53

24C. NAME OF CEMETERY OR CREMATORY

OAK LAWN

24D. LOCATION (City, town, or county)

BALTO CO. MD.

DATE RECEIVED BY LOCAL REGISTRAR

AUG 16 1953

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Bryley Funeral Home - Dundalk

ADDRESS

10001 Dundalk Rd. Dundalk, Md.

For the purpose of this report, the following information has been collected:  
The following items were found by the collector (see V.B. number 12)

1933

1933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

K-635  
K-615  
53 7334

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7334  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Kardon, Thomas

KARBAN

2. DATE  
OF  
DEATH

8-14-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

St. Agnes Hospital

C. CITY OR TOWN. (If outside corporate limits, write RURAL and give township)

Baltimore, Md.

24-01

40  
C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

1409 Hull St.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

9-8

9. AGE (In years,  
last birthday)

77

10 Under 1 Year  
Months: Days

11 Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Hungary

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Vincent

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs. Shugh, Meadow Rd.

ADDRESS

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Coronary insufficiency &  
DUE TO acute myocardial infarction

5 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) arteriosclerotic cardiovascular  
DUE TO disease

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 13, 1953, to Aug 14, 1953, that I last saw the  
deceased alive on Aug 14, 1953, and that death occurred at 4:15 P. M., from the causes and on the date stated above.

23A. SIGNATURE

James E. Rowe Jr. M. D.

23B. ADDRESS

St Agnes Hospital

23C. DATE SIGNED

8/14/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8/17/53

24C. NAME OF CEMETERY OR CREMATORY

Holy Cross

24D. LOCATION (City, town, or county)

Balto.

(State)

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

195307

25. FUNERAL DIRECTOR

Charles F. Dell

ADDRESS

1501 E. Fort Ave

1885

1885

5-4-8

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born



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7335  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7335

1. NAME OF DECEASED (Type or Print) <i>George M. Hilroy</i>		2. DATE OF DEATH <i>Aug 16, 1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>2743 Md Ave.</i> B. COUNTY <i>12-06</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>BALTO CITY, Md.</i>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>2743. Md Ave.</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Dec. 15-1899</i>
9. AGE (In years, last birthday) <i>53</i>		11. BIRTHPLACE (State or foreign country) <i>Pittston Pa</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, given if retired) <i>Tire Builder.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Schervuit Rubber Co.</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Michael Hilroy.</i>	
14. MOTHER'S MAIDEN NAME <i>Margaret Roach</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mary Hilroy 2743 Md. Ave.</i>	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CORONARY OCCLUSION. DUE TO ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH <i>15 min</i> <i>6 joints</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>8-16-53</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan 1, 1949</i> , to <i>Aug 16, 1953</i> , that I last saw the deceased alive on <i>Aug 15, 1953</i> , and that death occurred at <i>1:30 P.m.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>Robert H. Mortimer Jr.</i>		23B. ADDRESS <i>2706 St Paul St</i>	
23C. DATE SIGNED <i>8/16/53</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal.</i>		24B. DATE <i>8-16-53</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Pittston.</i>		24D. LOCATION (City, town, or county) (State) <i>Pa.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 17 1953</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>	
VS 150		FUNERAL DIRECTOR ADDRESS <i>William Cook Inc. 1217 St. Paul St.</i>	

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53 7336

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7336  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)2. DATE  
OF  
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTH PLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 176x

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-13-1953 8-14-1953 that I last saw the deceased alive on 8-14-1953, and that death occurred at 11:05 m. from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

STATE OF NEW YORK  
CERTIFICATE OF DEATH

1900

DECEASED

NAME OF DECEASED  
RESIDENCE  
CAUSE OF DEATH

DECEASED  
RESIDENCE  
CAUSE OF DEATH

1900

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

18. 442x

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/24, 1953, to 8/3, 1953, that I last saw the deceased alive on 8/1, 1953, and that death occurred at 6:45 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 17 1953

VS 150

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7337

2. DATE OF DEATH

8-13-53

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

2100 McCulloh

8. DATE OF BIRTH

2-15-1867

9. AGE (In years last birthday)

86

11 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

11. BIRTHPLACE (State or foreign country)

Staunton Va

12. CITIZEN OF WHAT COUNTRY?

U. S.

14. MOTHER'S MAIDEN NAME

Mary P.

17. INFORMANT

ADDRESS

Eva Robinson - 2100 McCulloh

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

(A) Hypertensive Cardio-Vascular Disease  
DUE TO Renal Disease

3 wks.

(B)

DUE TO

(C)

M. O.

601 N. Carrollton

8/14/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-17-53

24C. NAME OF CEMETERY OR CREMATORY

Mt. Zion Cem.

24D. LOCATION (City, town, or county)

Balt. Co. Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

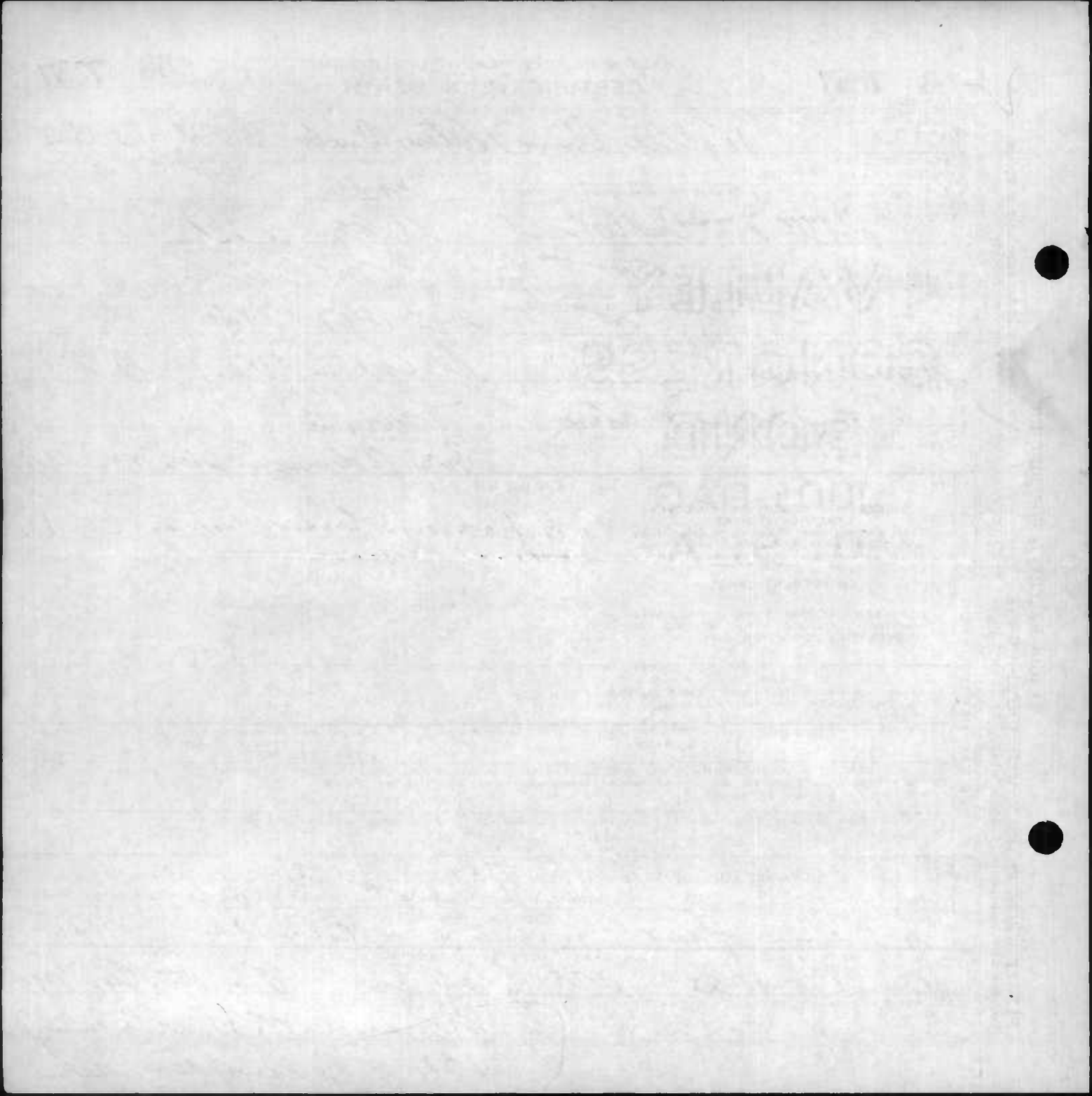
Huntington Williams

25. FUNERAL DIRECTOR

Samuel W. Sullivan

ADDRESS

1011 N. Arlington Ave





53-553

53 7338  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7338  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>JACOB DIAMOND</b>		2. DATE OF DEATH <b>8/16/53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
5. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Mary Hospital, Inc</b>		6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 6-03</b>	
7. LENGTH OF STAY IN BALTIMORE <b>55</b> Yrs. <b>Days</b>		8. STREET ADDRESS (If rural, give location) <b>8 N. Collington Ave.</b>	
9. SEX <b>M</b>	10. COLOR OR RACE <b>N</b>	11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	12. DATE OF BIRTH <b>1876</b>
13. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <b>Tailor</b>		14. AGE (In years last birthday) <b>77</b>	
15. KIND OF BUSINESS OR INDUSTRY		15. BIRTHPLACE (State or foreign country) <b>Russia</b>	
16. FATHER'S NAME <b>Arthur Diamond</b>		17. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
18. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		19. MOTHER'S MAIDEN NAME <b>Ross</b>	
20. SOCIAL SECURITY NO.		21. INFORMANT <b>Mrs Esther Sterling - same</b>	
22. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Complete heart block with Ventricular Fibrillation</b>		23. INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b>	
24. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arteriosclerotic Heart Disease with Hypertension</b>		25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
26. DATE OF OPERATION <b>8/15/53</b>		27. MAJOR FINDINGS OF OPERATION	
28. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		29. DATE SIGNED <b>8/16/53</b>	
30. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		31. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
32. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		33. TIME (Month) (Day) (Year) (Hour) INJURY	
34. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		35. HOW DID INJURY OCCUR?	
36. I hereby certify that I attended the deceased from <b>Aug 9</b> , 19 <b>53</b> to <b>Aug 16</b> , 19 <b>53</b> that I last saw the deceased alive on <b>Aug 16</b> , 19 <b>53</b> and that death occurred at <b>5:16 P.m.</b> , from the causes and on the date stated above.			
37. SIGNATURE <b>W. H. Henson</b>		38. ADDRESS <b>Mary Hospital</b>	
39. DATE SIGNED <b>8/16/53</b>		40. DATE SIGNED	
41. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		42. DATE <b>8-17-53</b>	
43. NAME OF CEMETERY OR CREMATORY <b>Rose dale</b>		44. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
45. DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 17 1953</b>		46. REGISTRAR'S SIGNATURE <b>Huntington Williams</b>	
47. FUNERAL DIRECTOR <b>W. H. Henson</b>		48. ADDRESS <b>2000 Eutan Pl</b>	

MEDICAL CERTIFICATION



B-62-6

53 7339

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7339

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John I. Burger

2. DATE OF DEATH  
AUG 15 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 16-06

D. STREET ADDRESS (If rural, give location)

2706 Edmondson Ave

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

12-22-17

9. AGE (In years last birthday)

35

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cab Driver

10B. KIND OF BUSINESS OR INDUSTRY

White Top

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Frank C. Burger

14. MOTHER'S MAIDEN NAME

Anna E. Duerr

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

NO

NO

16. SOCIAL SECURITY NO.

216.20.8546

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18. 401.3

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

Rheumatic pancarditis

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

1 wk!

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-15-1953 to 8-15-1953 that I last saw the deceased alive on 8-15-1953, and that death occurred at 11:20 P. M., from the causes and on the date stated above.

23A. SIGNATURE

John E. Hildebrand

M. O.

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

8-16-53

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8.19.53

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Balto.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 17 1953

H. T. Stansbury 2700 Edmondson Ave.

VS 50

68254

CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

Form No. 1

1919

1038

John J. ...

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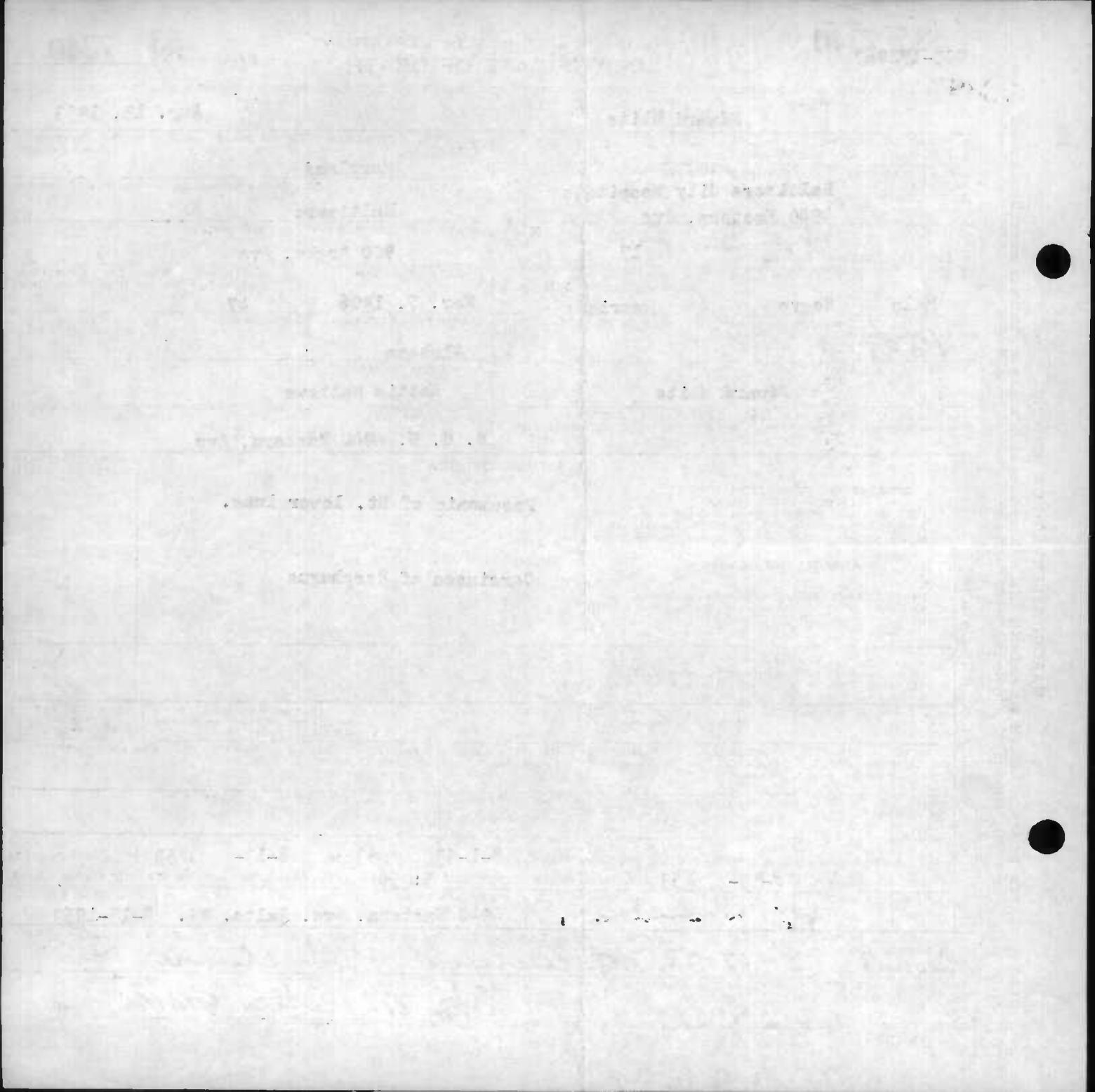
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-300  
53 7340  
ccc-172962

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7340

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Edward White</b>		2. DATE OF DEATH <b>Aug. 13, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern, Ave</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>17-01</b>			
31 c. Length of stay in Baltimore <b>17</b> <b>X</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>900 Argyle</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Mar. 7, 1906</b>	9. AGE (In years last birthday) <b>47</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PORTER</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PORTER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>	
13. FATHER'S NAME <b>Edward White</b>		14. MOTHER'S MAIDEN NAME <b>Hattie Mathews</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>B. G. H. 4940 Eastern, Ave</b>	
18. <b>150X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia of Rt. lower lung.</b> DUE TO ANTECEDENT CAUSES (B) <b>Carcinoma of Esophagus</b> DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>8-1-53</b> , 1953, to <b>8-13</b> , 1953 that I last saw the deceased alive on <b>8-13</b> , 1953, and that death occurred at <b>5:05pm.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <i>H. G. H. H. H.</i>		23B. ADDRESS <b>4940 Eastern, Ave. Balto. Md.</b>		23C. DATE SIGNED <b>8-13-1953</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-17-53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore 38.</b>		24E. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>		24F. LOCATION (City, town, or county) (State) <b>Baltimore 38.</b>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>Thurston M. Williams</i>		25. FUNERAL DIRECTOR ADDRESS <b>Wm. A. Jackson - 916 Pa. Ave.</b>	





S-635  
53 7341BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7341  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>MRS. ELDA B. SHERIDAN</i>		2. DATE OF DEATH <i>8-16-1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>14-02</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1700 EUTAW PL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>BAKTO-MD</i>			
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>1700 EUTAW PL</i>			
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>12-5-1886</i>	9. AGE (In years last birthday) <i>67</i>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SALES WOMAN</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>JOHNSTOWN - PA</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>DAVID BURKART</i>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>216-03-3315</i>		17. INFORMANT ADDRESS <i>MAX LEVY - 1700 EUTAW PL</i>	
18. <i>322.2</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Alcoholism</i> DUE TO (A) (B) (C)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>14 yrs.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Malnutrition, chronic</i>				<i>3 yrs.</i>	
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Oct 1946</i> to <i>Aug 16</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>Jan 12, 1953</i> , and that death occurred at <i>7:20 A.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Edward J. Cotter</i>		23B. ADDRESS M. D. <i>65. Reed Street</i>		23C. DATE SIGNED <i>Aug 16, 1953</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>		24B. DATE <i>8-17-53</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Stephen J. Conway Funeral Home</i>	
24D. LOCATION (City, town, or county) (State) <i>JOHNSTOWN - PENNA.</i>		25. FUNERAL DIRECTOR <i>Thomas J. Kenny Inc</i>		ADDRESS <i>490 99 1600 Hollins St</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 17 1953</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>			

MEDICAL CERTIFICATION

1947

22

RECEIVED

OFFICE OF THE SECRETARY

1947

1947

RECEIVED

1947

22

1947

22

1947

53 7342

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7342

BIRTH NO.

EMMA.

1. NAME OF DECEASED  
(Type or Print)

Emma Cottman

2. DATE  
OF  
DEATH

8/14/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution, residence  
before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)

443-Orchard st.

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give  
township)

Balt. Md. 11-03

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

443-Orchard st.

5. SEX

F.

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Sept. 6/1901

9. AGE (In years  
last birthday)

52

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balt. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

?

Waters

14. MOTHER'S MAIDEN NAME

Elizabeth Slony

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Elizabeth Cottman - Orchard St.

18. 550.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Peritonitis

DUE TO

1 day.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Acute Appendicitis

DUE TO

3 days.

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Sept 13/53

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH. ENTER IN  
PART I OR PART II20. AUTOPSY?  
YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐NOT WHILE ☐

m.

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/13, 1953, to 8/14, 1953, that I last saw the  
deceased alive on 8/13, 1953, and that death occurred at 5:20 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Herbert J. Taylor

23B. ADDRESS

325 W. Lombard St.

23C. DATE SIGNED

8/15/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

8/18/53

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

W. Halstead - 918 -

ADDRESS

Hendrix Hill ave.

AUG 17 1953  
VS 150

1848

23

1848



13-346

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7343

BIRTH NO. 53 7343

1. NAME OF DECEASED  
(Type or Print)

ELIZABETH VINDORA BUTLER

2. DATE  
OF  
DEATH

8/15/53

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Church Home &amp; Hospital

Yrs.

c. Length of stay in Baltimore

21

Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

10/31/1880

9. AGE (in years  
last birthday)

72

If Under 1 Year  
Months: Days: Hours: Min.10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Indiana

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Jeremiah Foreman

14. MOTHER'S MAIDEN NAME

Melinda Minnick

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Church Home &amp; Hospital

18. 420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Myocardial Infarction

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Arteriosclerosis Heart Disease etc.

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21a. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

m.

WHILE AT  
WORK ☐ NOT WHILE  
AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/13, 1953, to 8/15, 1953, that I last saw the  
deceased alive on 8/15, 1953, and that death occurred at 3:50 P.m., from the causes and on the date stated above.

23a. SIGNATURE

David F. Hansen

M. O.

23b. ADDRESS

Church Home &amp; Hospital

23c. DATE SIGNED

8/15/53

24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24b. DATE

8/18/53

24c. NAME OF CEMETERY OR CREMATORY

Parkwood Cem.

24d. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington, William

25. FUNERAL DIRECTOR

J. Fickner &amp; Sons

ADDRESS

Balto. 17, Md.

1. Name of deceased: *John Doe*  
2. Date of death: *1/15/41*  
3. Place of death: *Home*  
4. Cause of death: *Heart Disease*  
5. Age at death: *65*  
6. Sex: *Male*  
7. Race: *White*  
8. Marital status: *Married*  
9. Occupation: *Teacher*  
10. Signature of physician: *[Signature]*  
11. Signature of registrar: *[Signature]*  
12. Date of registration: *1/16/41*

13. Name of informant: *John Doe*  
14. Address of informant: *123 Main St, City, State*  
15. Signature of informant: *[Signature]*  
16. Date of completion: *1/16/41*  
17. Registrar's office: *City Health Department*  
18. Registrar's name: *[Name]*  
19. Registrar's signature: *[Signature]*  
20. Date of filing: *1/16/41*



H-422  
53 7344HOLZSWEIG  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7344  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Rose Holzswieg

2. DATE  
OF  
DEATH

Aug 17, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE 4613 Park Heights ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

E. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS 5500

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) .....  
DUE TO

Cerebral Hemorrhage

Few hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) .....  
DUE TO

Cardiovascular Disease

Many yrs.

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Asthma

Many yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

m.

WHILE AT ☐  
WORKNOT WHILE ☐  
AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 30, 1953, to Aug 17, 1953, that I last saw the  
deceased alive on Aug 15, 1953, and that death occurred at 6 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS 1126 W



4-620

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7345

53 7345  
Registered No.

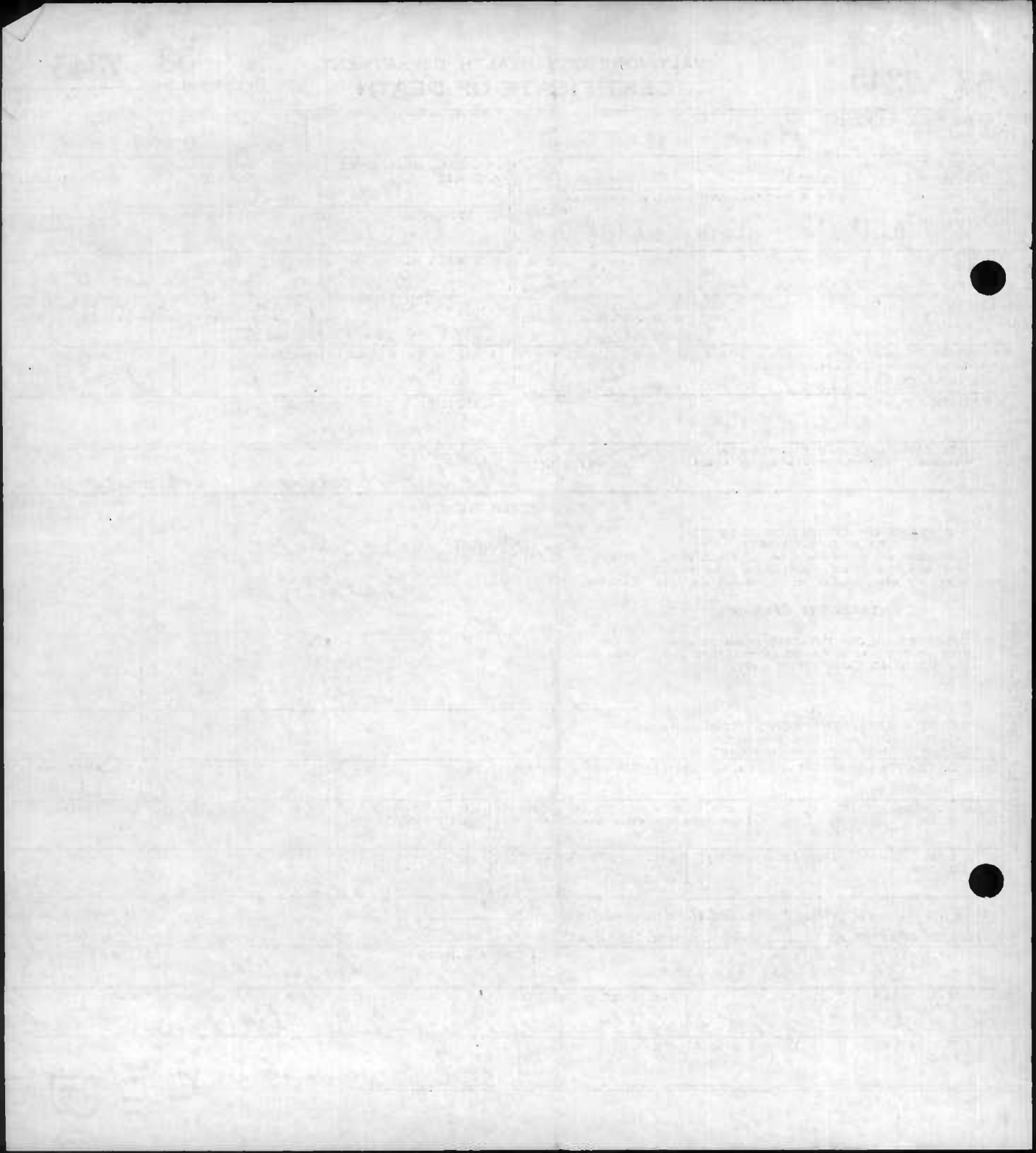
1. NAME OF DECEASED (Type or Print) <b>Meyer Hirsch</b>		2. DATE OF DEATH <b>8/17/53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <input checked="" type="checkbox"/>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Guthrie Hospital of Md.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 15-13</b>	
D. STREET ADDRESS (If rural, give location) <b>4336 Park Heights Ave #15</b>		5. SEX <b>Male</b> 6. COLOR OR RACE <b>W.</b> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	
8. DATE OF BIRTH <b>Oct 15, 1887</b> 9. AGE (In years last birthday) <b>65</b> 10. UNDER 1 YEAR Months: Days 11. UNDER 24 HOURS Hours: Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Grocer &amp; Store Owner Business</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or none) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hubert Hirsch</b>		ADDRESS <b>2601 Oswego Ave</b>	

MEDICAL CERTIFICATION

18. <b>331X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebro-vascular accident</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Accident</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>8/16</b> , 19 <b>53</b> , to <b>8/17</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>8/17</b> , 19 <b>53</b> , and that death occurred at <b>6:52 a.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Heinrich Hain</b>		23B. ADDRESS <b>Guthrie Hospital</b>		23C. DATE SIGNED <b>8/17/53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug 17/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Bobrovskiy Vasein Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25. FUNERAL DIRECTOR <b>Robert Lewinson</b>		ADDRESS <b>1126 W North Ave</b>	

2906A



K-650

**KEARNEY**  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. **53 7346****53 7346**

BIRTH NO

1. NAME OF DECEASED  
(Type or Print)**William R. Kearney**2. DATE  
OF  
DEATH**Aug 13, 1953**

3. PLACE OF DEATH:

A. Baltimore City, Maryland **Ad 25 on Ad RR**

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

B. COUNTY

**md Baltimore**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

**JOHNS HOPKINS HOSPITAL**

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

**Sparrows Pt 802 1st St 5300**

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

**Male**

6. COLOR OR RACE

**Colored**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**Married**

8. DATE OF BIRTH

**10-26-1907**

9. AGE (In years last birthday)

**45**

11 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Steel Worker**

10B. KIND OF BUSINESS OR INDUSTRY

**Bethlehem Steel**

11. BIRTHPLACE (State or foreign country)

**Sparrows Point, Md.**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**William H. Kearney**

14. MOTHER'S MAIDEN NAME

**Odie Wilson**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

**No**

16. SOCIAL SECURITY NO.

**Z13-09-0031**

17. INFORMANT

**JOHNS HOPKINS HOSPITAL**

ADDRESS

☒18. **022X**

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

**aneurysm of aorta**

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **8/9**, 19**53** to **8/13**, 19**53** that I last saw the deceased alive on **8/13**, 19**53** and that death occurred at **6:08 P.m.**, from the causes and on the date stated above.

23A. SIGNATURE

**Donald G. Mueller**

M. O.

**JOHNS HOPKINS HOSPITAL**

23C. DATE SIGNED

**8/14/53**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**8/16/53**

24C. NAME OF CEMETERY OR CREMATORY

**Arbutus Memorial Pk.**

24D. LOCATION (City, town, or county)

**Balto. Co., Md.**

(State)

DATE RECEIVED BY LOCAL REGISTRAR

**AUG 17 1953**

REGISTRAR'S SIGNATURE

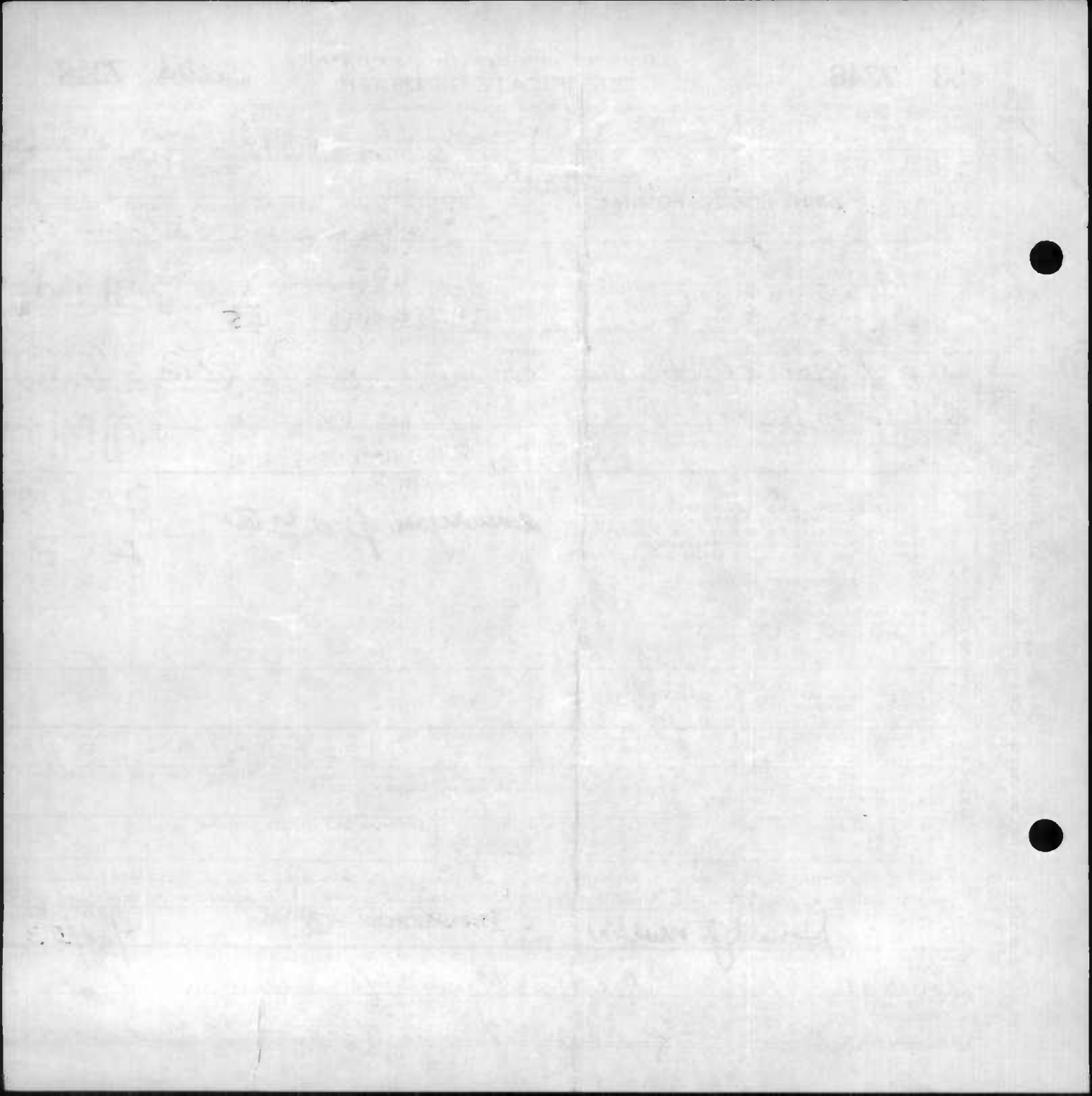
**Huntington Williams**

25. FUNERAL DIRECTOR

**William H. Williams**

ADDRESS

**802 Mad. Ave.**





53 7347

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7347

Registered No.

1. NAME OF DECEASED  
(Type or Print)

Lillian A. Butler

2. DATE  
OF  
DEATH

Aug 13, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission)

A. STATE Maryland B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

612 Baker St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 15-01

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

612 Baker St.

5. SEX

Female Colored

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct 2 1903

9. AGE (In years last birthday)

38

If Under 1 Year Months: Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laundress

10B. KIND OF BUSINESS OR INDUSTRY

Atrop.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Hewelyn Smith

14. MOTHER'S MAIDEN NAME

Annie Linnis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S NAME

Mr. Bernard Butler

612 Baker St.

18. 214X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Embolus

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Multinodular uterine fibroid 8/13/53

DUE TO Paralytic ileus

(C) 8/13/53

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

8/11/53

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Multinodular uterine fibroid

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/11, 1953 to 8/13, 1953 that I last saw the deceased alive on 8/13, 1953, and that death occurred at 4<sup>28</sup> P. M., from the causes and on the date stated above.

23A. SIGNATURE

H. Wellcome

23B. ADDRESS

M. D. 1131 Harlem Ave.

23C. DATE SIGNED

8/17/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug 12, 1953

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county) (State)

Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR

AUG 17 1953

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

1601 Miss Will Ave.

1947

23

1947

WALLACE

JOHN

JOHN

JOHN





CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

DATE OF DEATH  
PLACE OF DEATH

REPORTED BY

WALTER  
CONGRESS  
BOND  
LOCUS

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7349  
Registered No. 52-22445

BIRTH NO. 52-22445

1. NAME OF DECEASED  
(Type or Print)

FLORA D. HUNT

2. DATE  
OF  
DEATH

8/15/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

PROVIDENT HOSPITAL

C. CITY OR TOWN

BALTIMORE

D. STREET ADDRESS (If rural, give location)

743 N. FULTON AV.

C. Length of stay in Baltimore

LIFE

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
SINGLE

8. DATE OF BIRTH

7/31/1952

9. AGE (In years  
last birthday)

1

If Under 1 Year  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

INFANT

10B. KIND OF BUSINESS OR  
INDUSTRY

INFANT

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

LEE O. HUNT

14. MOTHER'S MAIDEN NAME

BESSIE ALEXANDER

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

NO

16. SOCIAL  
SECURITY NO.  
NONE

17. INFORMANT

ADDRESS

BESSIE HUNT(M) 743 FULTON AV.

18. 491x

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) *Bronchopneumonia*  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)   
DUE TO  
(C)   
DUE TOII  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONOITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH. ENTER IN  
PART I OR PART II20. AUTOPSY?  
YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-15, 1953, to 8-15, 1953 that I last saw the  
deceased alive on 8-15, 1953, and that death occurred at 1:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL

8/17/53

MT. AUBURN CEMETERY

BALTIMOR MD.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 17 1953

Huntington Williams, M.D.

CHARLES G. COOPER-512 CARROLLTON AV.

*Charles G. Cooper*

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53-7350		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 53 7350	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		John N. Stebbing		2. DATE OF DEATH AUG 15 1953	
3. PLACE OF DEATH: A. Baltimore City, Maryland		Emergency Rm		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md	
B. FULL NAME OF HOSPITAL OR INSTITUTION		JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 7-04	
c. Length of stay in Baltimore		Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 1048 N. BROADWAY	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 3/31/1880	9. AGE (In years last birthday) 73	10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lather		10B. KIND OF BUSINESS OR INDUSTRY Own Business		11. BIRTHPLACE (State or foreign country) Perryville Md.	
13. FATHER'S NAME (Unknown) Stebbing		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-14-0847		17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL	
18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction		CAUSE OF DEATH (A) DUE TO Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2.2 hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO		(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CERTIFICATION APPROVED BY J. H. Fisher M.D. CHIEF OR ASST. MEDICAL EXAMINER			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 8-15-1953, and that death occurred at 6:59 Am., from the causes and on the date stated above.					
23A. SIGNATURE Lawrence L. Uebel		23B. ADDRESS JOHNS HOPKINS HOSPITAL		23C. DATE SIGNED 15 Aug 1953	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/18/53		24C. NAME OF CEMETERY OR CREMATORY Parkwood	
24D. LOCATION (City, town, or county) (State) Parkville Md.		24E. FUNERAL DIRECTOR B. W. BOK INC.		24F. ADDRESS 1217 S. Paul St.	
DATE RECEIVED BY LOCAL REGISTRAR AUG 17 1953		REGISTRAR'S SIGNATURE Huntington		VS 150	

62431

10-10-10

John Stepping

MD

1011

1011 N Broadway

or 1011

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1011 N Broadway

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4852 Med. Ex Case - Released to Hosp. 53 535H60 53 7351  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Frances Schuler</i>		2. DATE OF DEATH <i>Aug 16, 1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Emergency Unit</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY		C. CITY OR TOWN (If outside corporate limits, write full name and give township) <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		D. STREET ADDRESS (If rural, give location) <i>2813 Erdman Ave</i>			
c. Length of stay in Baltimore <i>33 2/3</i>		Yrs. Mos. Days			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>1-13-1896</i>	9. AGE (In years last birthday) <i>57</i>	If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>George Schuler</i>		14. MOTHER'S MAIDEN NAME <i>Madelaine Dickas</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. <i>JOHNS HOPKINS HOSPITAL</i> ADDRESS	
18. <i>420.1 and 260X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Ant. Myocardial Infarction</i> DUE TO <i>Coronary Occlusion</i> DUE TO <i>Hypertensive Arteriosclerotic Cardiovascular Disease</i> DUE TO <i>Diabetes mellitus</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>Overnight?</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CERTIFICATION APPROVED BY <i>R. Schuler</i>	
19A. DATE OF OPERATION <i>8-16-53</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS CHIEF OR ASST. CAUSE OF DEATH, ENTER IN PART I OR PART II YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>8-16-1953</i> to <i>8-16-1953</i> , that I last saw the deceased alive on <i>8-16-1953</i> , and that death occurred at <i>1:14 p.m.</i> from the causes and on the date stated above.					
23A. SIGNATURE <i>Edward L. Alexander Jr.</i>		23B. <i>JOHNS HOPKINS HOSPITAL</i> M. O.		23C. DATE SIGNED <i>16 Aug 1953</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/20/53</i>		24C. NAME OF CEMETERY OR CREMATORY <i>U. S. National</i>	
24D. LOCATION (City, town, or county) <i>Balto. Md.</i>		24E. LOCAL REGISTRAR <i>Huntington Williams</i>		24F. FUNERAL DIRECTOR <i>Mr. Bok Inc. 1217 St. Paul St.</i>	

1933

OFFICE OF THE  
SHERIFF

1933

BOND

CONTRACT

WARRANT

Med. Examiner Case - Released to Hosp. To be appor.

53 L-7352

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7352

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		Howard C. Lancaster		AUG 15 1953	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
Emergency Room		A. STATE Md.			
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN			
JOHNS HOPKINS HOSPITAL		Baltimore			
c. Length of stay in Baltimore		D. STREET ADDRESS (if rural, give location)			
Yrs. Mos. Days		710 Montford Ave.			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Year Months: Days
male	white	married	6/10/1897	56	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Maintenance Man		Balt. City Parks		Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
(Unknown) Lancaster		Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMATION ADDRESS	
Yes		41. W. #1 213-12-0373		JOHNS HOPKINS HOSPITAL	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1		(A) Infected myocardium, acute		1 hr.	
ANTECEDENT CAUSES		(B) Coronary atherosclerosis		?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		19C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		19C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 8-15-1953, and that death occurred at 8:10 Am., from the causes and on the date stated above.					
23A. SIGNATURE		23B. ADDRESS		23C. DATE SIGNED	
John L. Hedeman		JOHNS HOPKINS HOSPITAL		8-15-53	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		8/18/53		U.S. National	
24D. LOCATION (City, town, or county)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
Balt. Md.		Huntington Williams, Mortuary Inc.		1217 St. Paul St.	
DATE RECEIVED BY LOCAL REGISTRAR		AUG 17 1953			



1913

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

1913

DATE OF DEATH  
PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

SIGNATURE

DATE

1913

1913



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

53 7353  
Registered No.

5-315  
53 7353  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>Mary S. Stevenson</u>			2. DATE OF DEATH <u>8-15-1953</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore City</u>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mercy Hospital</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>12-05</u>		
C. Length of stay in Baltimore <u>life</u>			D. STREET ADDRESS (If rural, give location) <u>1819 N. <del>Calvert</del> Calvert.</u>		
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 8, 1899</u>		9. AGE (In years last birthday) <u>53</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>
13. FATHER'S NAME <u>McKean</u>			14. MOTHER'S MAIDEN NAME <u>Mary Maclen</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Theresa Stevenson</u> ADDRESS <u>8017 N. Calvert St.</u>

18. <u>241X and 171X</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <u>Ventricular Fibrillation</u>		<u>10 minutes</u>
ANTECEDENT CAUSES		(B) <u>Hypox thorax</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) <u>Status Asthmaticus</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>Carcinoma of Cervix uteri</u>		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Aug 14, 1953, to Aug 15, 1953 that I last saw the deceased alive on Aug 15, 1953, and that death occurred at 12 45 A. m., from the causes and on the date stated above.

23A. SIGNATURE <u>Corbett Latimer Quinn</u> M. D.		23B. ADDRESS <u>Mercy Hospital</u>		23C. DATE SIGNED <u>Aug 15, 1953</u>
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>8/18/53</u>	24C. NAME OF CEMETERY OR <u>New Cathedral</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>AUG 17 1953</u>	REGISTRAR'S SIGNATURE <u>William</u>	25. FUNERAL DIRECTOR <u>St. M. Cook, Inc.</u> ADDRESS <u>1217 St. Paul St.</u>		

1000

STATE OF NEW YORK  
CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		OCCUPATION		MARRIAGE		RELIGION	
MANNER OF DEATH		CAUSE OF DEATH		MEDICAL HISTORY		TREATMENT		POST-MORTEM		BURIAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF SIGNATURE		PLACE OF SIGNATURE	

D-250

53 7354

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

X Registered No. 53 7354

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mr. CHARLES DIXON

2. DATE  
OF  
DEATH

16 August 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

Carroll

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Church Home and Hospital

C. CITY OR TOWN

Sykesville

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5600

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

April 5, 1884

9. AGE (in years  
last birthday)

69 yrs

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR  
INDUSTRY

Hospital Attendant

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

Maryland

13. FATHER'S NAME

Mr. Frederick Dixon

14. MOTHER'S MAIDEN NAME

Mary E. Browning

U. S. A.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs. Edna. Dixon

ADDRESS

Sykesville Md.

18. 150X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Carcinoma Esophagus

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

29 hrs 45 min

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

July 1953

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of Esophagus

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 15, 1953 to August 16, 1953 that I last saw the  
deceased alive on August 16, 1953 and that death occurred at 10 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Oshard Sivabutana

23B. ADDRESS

Church Home Hospital

23C. DATE SIGNED

16 August 1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Removal

24B. DATE

6/17/53

24C. PLACE OF BURIAL, CREMATION, REMOVAL

Sykesville

24D. LOCATION (City, town, or county)

Carroll Co. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William

25. FUNERAL DIRECTOR

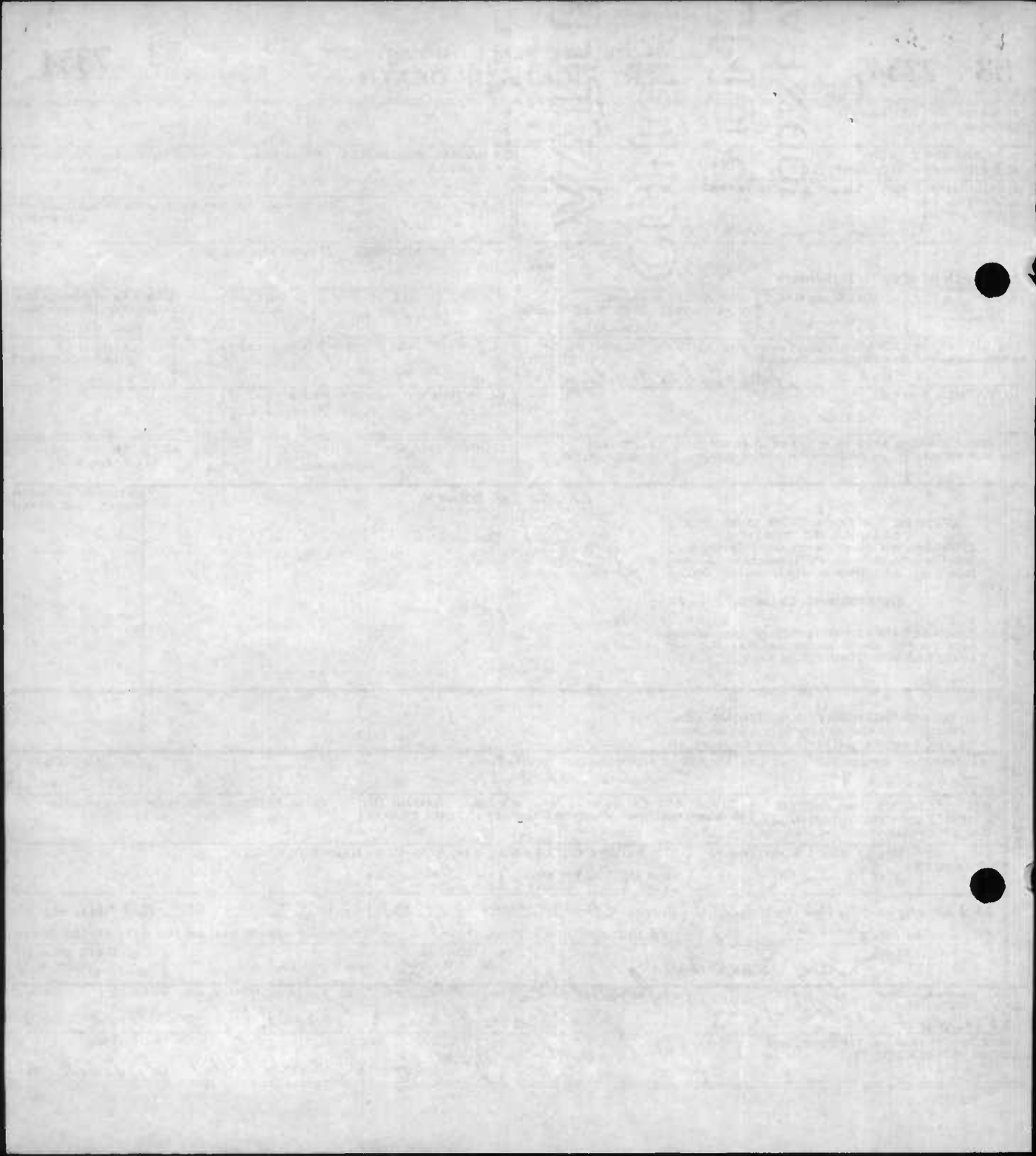
Cook Inc. 1217 St. Paul St

ADDRESS

VS 150

730 FT

MEDICAL CERTIFICATION



0-540

53 7355

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7355  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Margaret M. O'Neill

2. DATE  
OF  
DEATH

Aug 17-1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Md.

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

University Hospital

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

735 W. Cross St.

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct. 29, 1913

9. AGE (In years  
last birthday)

60

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William Vettters

14. MOTHER'S MAIDEN NAME

Caroline Stewart

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

J. LEO O'NEILL-735 W CROSS ST

18. 578X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Gastro Intestinal  
bleeding - cause  
undetermined

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) .....  
DUE TO .....  
(C) .....INTERVAL BETWEEN  
ONSET AND DEATH

1st time

May '52

Last 4 days  
this  
admission

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/15/1953, to 8/17/1953, that I last saw the  
deceased alive on 8/17/1953, and that death occurred at 6:30 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Lewis C. Richmond, Jr. M. O.

23B. ADDRESS

4630 Marjondene Rd.

23C. DATE SIGNED

8/17/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

8-20-53

24C. NAME OF CEMETERY OR CREMATORY

CATHEDRAL CEM.

24D. LOCATION (City, town, or county)

BALTO MD

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

AUG 17 1953

REGISTRAR'S SIGNATURE

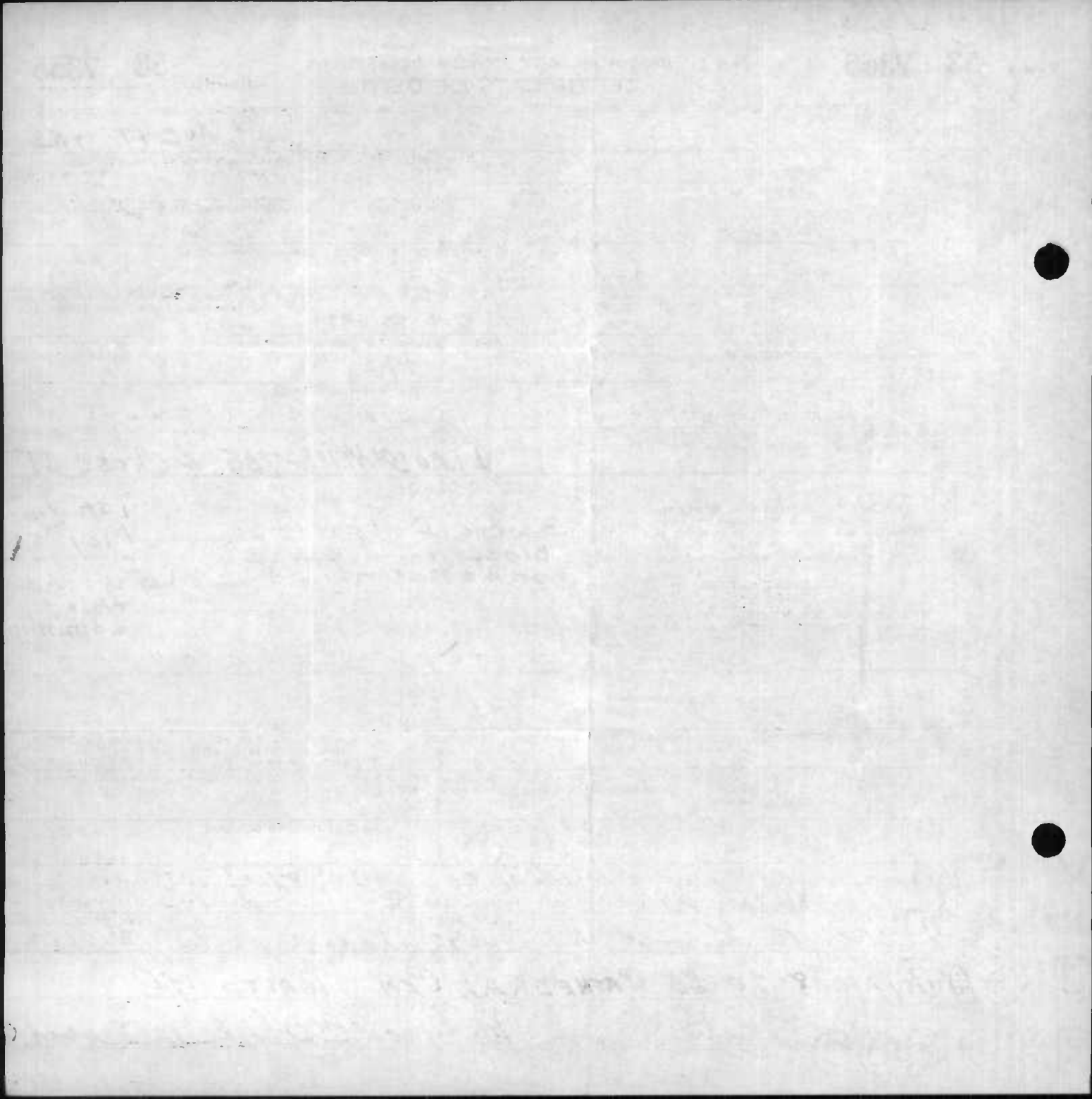
Huntington Williams

25. FUNERAL DIRECTOR

Bernard C. Harte

ADDRESS

131 E. Harte





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. **53 7356**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Essie Hall*

2. DATE OF DEATH *August 15, 1953*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission)  
A. STATE *md*  
B. COUNTY *15-01*

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION *1330 n. Stricker st*

CITY OR TOWN (If outside corporate limits, give RURAL and give township)  
*Balto*

c. Length of stay in Baltimore *Life*

D. STREET ADDRESS (If rural, give location)  
*1330 n. Stricker st*

5. SEX *7*

6. COLOR OR RACE *C*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
*m*

8. DATE OF BIRTH

*June 18, 1893*

9. AGE (In years last birthday)

*60*

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
*House wife*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*and*

12. CITIZEN OF WHAT COUNTRY?  
*U.S.A.*

13. FATHER'S NAME

*William Stewart*

14. MOTHER'S MAIDEN NAME

*Sulia Hawkins*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Arnon Hall 1330 n. Stricker st*

18. *420.1 and 260x*  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO

*Coronary Thrombosis*

INTERVAL BETWEEN ONSET AND DEATH  
*2 mps.*

ANTECEDENT CAUSES

(B) DUE TO

*Arteriosclerosis & Diabetes*

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION *0*

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *1946*, 19 *19*, to *Aug 15*, 19 *54*, that I last saw the deceased alive on *Aug 11*, 19 *53*, and that death occurred at *3 9* m., from the causes and on the date stated above.

23A. SIGNATURE

*Dr. E. Julian*

23B. ADDRESS

*511 N. Schuler St.*

23C. DATE SIGNED

*8/17/53*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*8-18-53*

24C. NAME OF CEMETERY OR CREMATORY

*and Zion Cem. and*

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

*AUG 17 1953*

REGISTRAR'S SIGNATURE

*Huntington Williams, M.D.*

25. FUNERAL DIRECTOR

*George S. Kellogg*

ADDRESS

*1303 Prestman st*



B-650

53 7357

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7357

1. NAME OF DECEASED (Type or Print) <b>MARY BARRON</b>		2. DATE OF DEATH <b>August 14, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1-01</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>831 S. ELLWOOD AVE</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE</b>	
D. STREET ADDRESS (If rural, give location) <b>831 S. ELLWOOD AVE</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>		8. DATE OF BIRTH <b>Aug. 9, 1886</b>	
9. AGE (In years last birthday) <b>67</b>		10. Under 1 Year Months: Days	
11. Under 24 Hours Hours: Min.		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
13. FATHER'S NAME <b>RICHARD BARRON</b>		14. MOTHER'S MAIDEN NAME <b>MARY TIEMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>SISTER- ELLEN BARRON</b>		ADDRESS <b>831 S ELLWOOD</b>	
18. 450.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Generalized arteriosclerosis</b> CAUSE OF DEATH <b>Malnutrition</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>May 10, 1950</b> to <b>Aug 14, 1953</b> , that I last saw the deceased alive on <b>Aug 14, 1953</b> , and that death occurred at <b>1142 PM</b> from the causes and on the date stated above.			
23A. SIGNATURE <b>L. A. Flanagan Jr. - M.D.</b>		23B. ADDRESS <b>3501 Fair Ave.</b>	
23C. DATE SIGNED <b>8-17-53</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>Aug 18, 1953</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>FREDERICK, RD. BALTIMORE</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 17 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	
25. FUNERAL DIRECTOR <b>John A. MORAN, 3000 E. BALTIMORE</b>		ADDRESS <b>BALTIMORE MD</b>	

3501 Taylor

C-400  
53 7358BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7358

1. NAME OF DECEASED (Type or Print) <b>ORA, COLE</b>		2. DATE OF DEATH <b>8-14-53</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write U.R.A.L. and give township) <b>Baltimore</b>	
d. Length of stay in Baltimore		e. STREET ADDRESS (If rural, give location) <b>1720 N. Carey St.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>ed</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Sept. 19, 1904</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H. Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>48</b>
11. BIRTHPLACE (State or foreign country) <b>Wilson N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John L. Lorton</b>		14. MOTHER'S MAIDEN NAME <b>S. S. Lorton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Charles Cole</b>		ADDRESS <b>1720 N. Carey St.</b>	

## CAUSE OF DEATH

18. **443X**  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Cerebro-vascular Accident**

DUE TO

(B) **Hypertensive Heart Disease**

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Aug. 7**, 1953, to **Aug. 14**, 1953, that I last saw the deceased alive on **Aug. 14**, 1953, and that death occurred at **8:00 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE <b>George R. Lyons</b> M. O.		23B. ADDRESS <b>Provident Hospital</b>		23C. DATE SIGNED <b>8-14-53</b>	
--	--	---	--	------------------------------------	--

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/18/1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		24D. LOCATION (City, town, or county) <b>St. Mary's</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 17 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>		25. FUNERAL DIRECTOR <b>W. H. Williams</b>		ADDRESS <b>Schroeder</b>	

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of \_\_\_\_\_

City of \_\_\_\_\_

On the \_\_\_\_\_ day of \_\_\_\_\_

19\_\_\_\_

at \_\_\_\_\_

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7359  
Registered No.

BIRTH NO. 52-13830

1. NAME OF DECEASED  
(Type or Print)

KEVIN HARPER

2. DATE  
OF  
DEATH

8-14-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

761 W. Mulberry St

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto.

D. STREET ADDRESS (If rural, give location)

761 W. Mulberry St

5. SEX

Male

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

6/17/1952

9. AGE (in years

last birthday)

If Under 1 Year

Months; Days

If Under 24 Hours

Hours; Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTH PLACE (State or foreign country)

Balto.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Marion Harper

14. MOTHER'S MAIDEN NAME

Mario Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no or unknown)

(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mario Taylor

ADDRESS

761 W. Mulberry St

18. 570.3

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

ACUTE PURULENT

DUE TO

PERITONITIS DUE TO

ANTECEDENT CAUSES

(B)

COLICULUS, SMALL INTESTINE

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I certify that I took charge of the remains described above, held an PARTIAL AUTOPSY thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Joseph A. Jachimczyk

M.D.

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

8-14-53.

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/17/1953

24C. NAME OF CEMETERY OR CREMATORY

W. T. Arkundin Balto

24D. LOCATION (City, town, or county)

Balto.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 17 1953

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

W. H. Williams

ADDRESS

W. H. Williams

1253

1253

1253

1253

THE FINEST  
POLYMER DUE TO  
NATURAL SUBSTANCES

PATENT A-1253

1253

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D-520  
53 7360BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7360  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Maudie Dennis</i>		2. DATE OF DEATH <i>Aug 15, 1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Dist 4</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>md.</i> B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>			
C. Length of stay in Baltimore <i>33</i> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>870 W. Fayette St.</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>		8. DATE OF BIRTH <i>3-27-1890</i>	9. AGE (In years last birthday) <i>63</i> If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Pa.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Samuel Baldwin</i>		14. MOTHER'S MAIDEN NAME <i>Mary</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>	
18. <i>445X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Kremia</i> DUE TO ANTECEDENT CAUSES <i>Malignant hypertension</i> DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>7/30</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <i>7/30</i> , 19 <i>53</i> , to <i>8/15</i> , 19 <i>53</i> that I last saw the deceased alive on <i>8/15</i> , 19 <i>53</i> , and that death occurred at <i>4:10 P.m.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>Henry M. Wagner Jr.</i>		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>8/15/53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/19/53</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Balto. National Cem</i>	
24D. LOCATION (City, town, or county) <i>Balto Md</i>		25. FUNERAL DIRECTOR <i>Huntington Williams, M.D.</i>		25. ADDRESS <i>W. Williams</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 17 1953</i>		VS 150			

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

K-252

53 7361

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7361

1. NAME OF DECEASED  
(Type or Print)

Joseph Kazanowski

2. DATE  
OF  
DEATH

Aug, 16, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland 220 S. Chester Street

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

At Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE Maryland B. COUNTY 2-01C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore-31,

D. STREET ADDRESS (If rural, give location)

220 South Chester Street

c. Length of stay in Baltimore 50yrs

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov, 3-1889

9. AGE (in years last birthday)

63

10. Under 1 Year 11. Under 24 Hours

Months: Days Hours: Min.

9 13

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel Co.

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

none

13. FATHER'S NAME

Leopold Kazanowski

14. MOTHER'S MAIDEN NAME

Elizabeth

??

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

213-07-3953

17. INFORMANT

ADDRESS

Anna Kazanowski 220 South Chester Street

18. 581.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic cirrhosis of the liver

?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis

?

DUE TO

(C) Myocardial insufficiency

3 days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Chronic mitral regurgitation

?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 19, 1953 to August 16, 1953 that I last saw the deceased alive on Aug. 13, 1953. and that death occurred at 2:30 P. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

S. O. Bronas

M. D.

2037 O'Donnell St., Baltimore

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. PLACE OF BURIAL

Aug 19, 1953

24C. NAME OF CEMETERY OR CREMATORY

St. Stanislaus Cemetery

24D. LOCATION (City, town, or county)

1300 Dundalk Ave-Balto, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 17 1953

Huntington Williams, M.D.

George R. Weber 705 S. Ann St.

VS 150

9703A

MEDICAL CERTIFICATION

1987 03

UNITED STATES DEPARTMENT OF AGRICULTURE

AGRICULTURAL CREDIT

1987

UNITED STATES DEPARTMENT OF AGRICULTURE

AGRICULTURAL CREDIT

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AGRICULTURAL CREDIT



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **53 7362**

**BIRTH NO.** **53 7362**

**1. NAME OF DECEASED** (Type or Print) **Norothy Hudson**

**2. DATE OF DEATH** **AUG 14 1953**

**3. PLACE OF DEATH:**  
A. Baltimore City, Maryland **Med. Center**  
B. FULL NAME OF (If not in hospital or institution, give street address or location)  
**JOHNS HOPKINS HOSPITAL**

**4. USUAL RESIDENCE** (Where deceased lived, If institution: residence before admission)  
A. STATE **Md.**  
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore 7-05**  
D. STREET ADDRESS (If rural, give location)  
**1603 E. MADISON ST.**

**5. SEX** **female** **6. COLOR OR RACE** **colored** **7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)** **W**

**8. DATE OF BIRTH** **2-28-18** **9. AGE (In years last birthday)** **35** **10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)** **Vegetable Dealer** **10B. KIND OF BUSINESS OR INDUSTRY** **Phillips Can. Co.** **11. BIRTHPLACE (State or foreign country)** **Cannon Del.** **12. CITIZEN OF WHAT COUNTRY?** **U. S. A.**

**13. FATHER'S NAME** **Joseph Thompson** **14. MOTHER'S MATHEN NAME** **Nora Dixon**

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no or unknown) **No** **16. SOCIAL SECURITY NO.** **17. INFORMANT** **JOHNS HOPKINS HOSPITAL** **ADDRESS**

**18. 600.0** **CAUSE OF DEATH** **Uremia** **INTERVAL BETWEEN ONSET AND DEATH**

**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) **(A) DUE TO**

**ANTECEDENT CAUSES** **(B) DUE TO** **Chronic pyelonephritis**

**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.** **(C)**

**II** **OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.**

**19A. DATE OF OPERATION** **19B. CONDITION FOR WHICH OPERATION WAS PERFORMED** **IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II** **20. AUTOPSY?** YES ☐ NO ☒

**21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)** **21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)** **21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?**

**21D. TIME (Month) (Day) (Year) (Hour) OF INJURY** **21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐** **21F. HOW DID INJURY OCCUR?**

**22. I hereby certify that I attended the deceased from 8-4-1953 to 8-14-1953 that I last saw the deceased alive on 8-14-1953 and that death occurred at 4 A m., from the causes and on the date stated above.**

**23A. SIGNATURE** **Henry N. Wagner** **23B. ADDRESS** **JOHNS HOPKINS HOSPITAL** **23C. DATE SIGNED** **8/15/53**

**24A. BURIAL, CREMATION, REMOVAL (Specify)** **24B. DATE** **24C. NAME OF CEMETERY OR CREMATORY** **24D. LOCATION (City, town, or county) (State)**

**Burial** **8-17-1953** **Mt. Auburn Cem.** **Baltimore, Md.**

**DATE RECEIVED BY LOCAL REGISTRAR** **REGISTRAR'S SIGNATURE** **25. FUNERAL DIRECTOR** **ADDRESS**

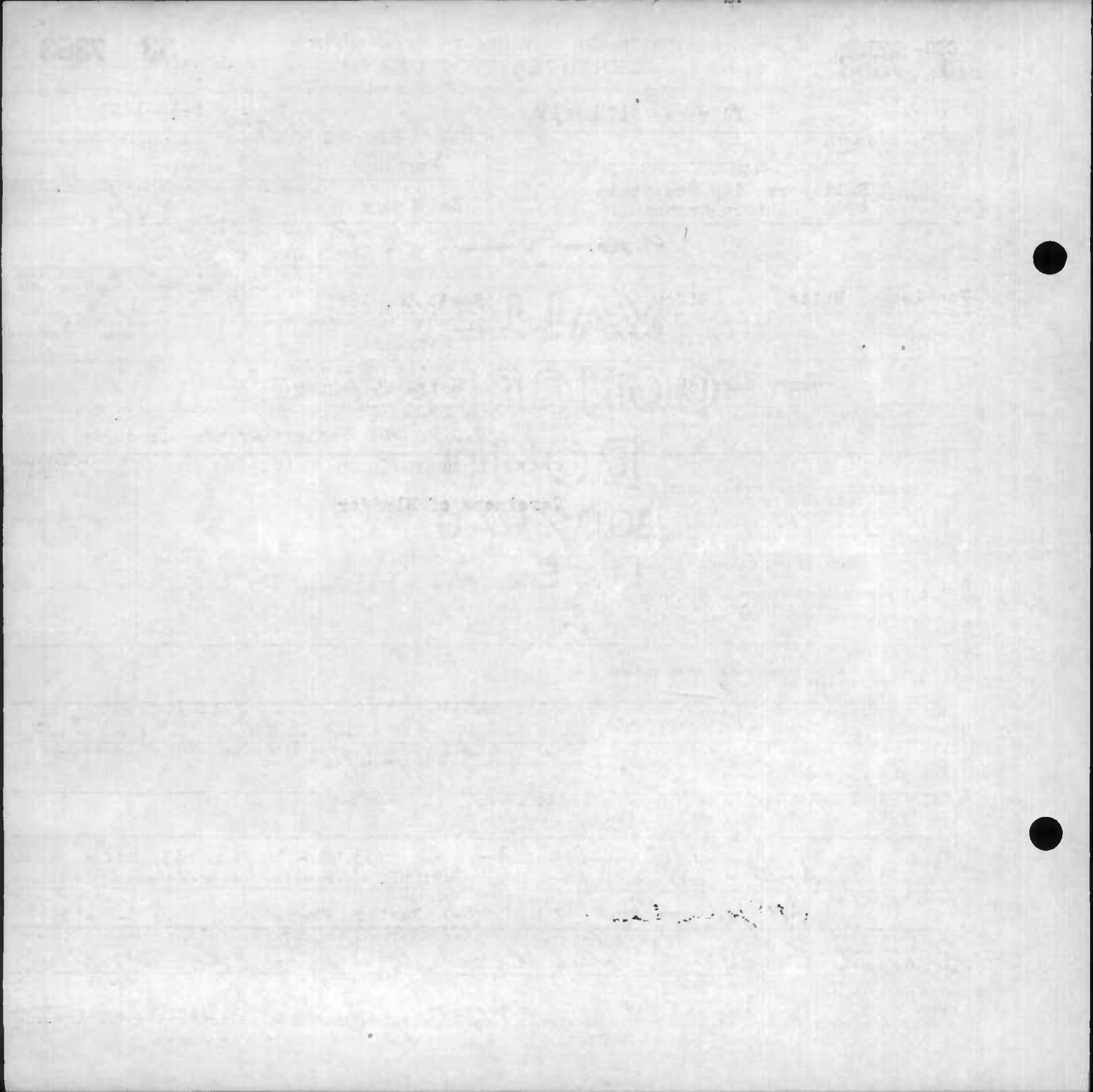
**AUG 17 1953** **Huntington** **Randolph J. Collick** **1412 E. Preston**

Chronic pyelitis

Chronic pyelitis

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-440 CCG-173206 53 7363		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 53 7363	
1. NAME OF DECEASED (Type or Print) <b>Florence Gillooly</b>			2. DATE OF DEATH <b>8-14-1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
31 c. Length of stay in Baltimore <b>67 yrs.</b>			d. STREET ADDRESS (If rural, give location) <b>404 East Chase St. #2</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Sept. 10, 1885</b>	9. AGE (In years last birthday) <b>67</b>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H. W.</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Gen Home</b>		
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Henry Garrish</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Wagner</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>B.C.H. 4940 Eastern Avenue (records)</b>		
18. <b>181X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Bladder</b> DUE TO			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>8-8-</b> , 1953, to <b>8-14-</b> , 1953, that I last saw the deceased alive on <b>8-14-</b> , 1953, and that death occurred at <b>9:00 p.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>H. C. Johnson</b>		23B. ADDRESS <b>4940 Eastern Avenue</b>		23C. DATE SIGNED <b>8-14-1953</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Aug. 18/53</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Landon M. B. B. B.</b>		24D. LOCATION (City, town, or county) (State) <b>29. Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 17 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington W. Williams</b>		25. FUNERAL DIRECTOR'S ADDRESS <b>Harry B. Smith, 4101 Edmondson</b>	



42842 Med. Ex. Case - Released to Hosp.  
53 M-256 3864  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH  
Registered No. 53 7364

BIRTH NO

1. NAME OF DECEASED (Type or Print) *Carrie McNeil*

2. DATE OF DEATH *Aug 16, 1953*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland *Emerg Unit*

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE *MD*  
B. COUNTY *5-06*

5. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION *JOHNS HOPKINS HOSPITAL*

6. CITY OR TOWN (If outside corporate limits, with R.R. and give township)  
*Baltimore*

7. STREET ADDRESS (If rural, give location)  
*1105 E. Monument St*

8. Length of stay in Baltimore  
Yrs. *33*  
Mos. *33*  
Days *33*

9. SEX *Female*

10. COLOR OR RACE *Colored*

11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
*Widowed*

12. DATE OF BIRTH *5-1-1888*

13. AGE (In years last birthday) *65*

14. If Under 1 Year Months: Days  
15. If Under 24 Hours Hours: Min.

16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
*Housewife*

17. KIND OF BUSINESS OR INDUSTRY

18. BIRTHPLACE (State or foreign country)  
*N. Carolina*

19. CITIZEN OF WHAT COUNTRY?

20. FATHER'S NAME  
*Milton McCarver*

21. MOTHER'S MAIDEN NAME  
*Freda McNeil*

22. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no or unknown) (If yes, give war or dates of service)

23. SOCIAL SECURITY NO.

24. INFORMATION  
*JOHNS HOPKINS HOSPITAL*

25. ADDRESS

18. *420.1 and 260x*  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  
*Myocardial Infarction*  
CAUSE OF DEATH  
(A) *Myocardial Infarction*  
DUE TO  
(B) *Coronary occlusion*  
DUE TO  
(C) *Hypertensive arteriosclerotic Cardiovascular disease*  
INTERVAL BETWEEN ONSET AND DEATH  
*?*

19. ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  
*Diabetes mellitus*

21. DATE OF OPERATION *2*

22. CONDITION FOR WHICH OPERATION WAS PERFORMED

23. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

24. AUTOPSY?  
YES ☒ NO ☐

25. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) ☐

26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

27. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

28. TIME (Month) (Day) (Year) (Hour) OF INJURY

29. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐  
*POA*

30. HOW DID INJURY OCCUR?

31. I hereby certify that I attended the deceased from *8-16-*, 19*53* to *12-12-*, 19*53*, that I last saw the deceased alive on *12-12-*, 19*53*, and that death occurred at *12:12 PM*, from the causes and on the date stated above.

32. SIGNATURE  
*Edward L. Alvord, Jr.*

33. *JOHNS HOPKINS HOSPITAL*

34. DATE SIGNED  
*17 August 53*

35. BURIAL, CREMATION, REMOVAL (Specify)  
*Burial*

36. DATE  
*Aug 17/53*

37. NAME OF CEMETERY OR CREMATORY  
*Mt. Calvary Cem*

38. LOCATION (City, town, or county) (State)  
*A.A. County, Md*

39. DATE RECEIVED BY LOCAL REGISTRAR  
*AUG 17 1953*

40. REGISTRAR'S SIGNATURE  
*Huntington Williams, M.D.*

41. FUNERAL DIRECTOR  
*Wm. O. Webb & Co.*

42. ADDRESS  
*1129 N. Caroline St.*

VS 150

1000

OFFICE OF DEATH





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **53 7365**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

**Andrew M. Flury**

2. DATE  
OF  
DEATH

**August 13, 1953**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

**Balto.**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

**St. Joseph's Hospital  
1400 N. Caroline St.**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

**Md.**

B. COUNTY

**Maryland  
Baltimore**

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

**5143 Frederick Ave.**

C. Length of stay in Baltimore

**Life**

Yrs.  
Mos.  
Days

5. SEX

**Male**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**Married**

8. DATE OF BIRTH

**8-2-13**

9. AGE (In years last birthday)

**40**

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Supervisor  
13. FATHER'S NAME**

10B. KIND OF BUSINESS OR INDUSTRY

**Kopper's Company**

11. BIRTHPLACE (State or foreign country)

**Baltimore**

12. CITIZEN OF WHAT COUNTRY?

**USA**

14. MOTHER'S MAIDEN NAME

**Mamie Lambdin**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

**Helen Flury wife**

ADDRESS

**same**

18. **526x**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Pulmonary Suppuration**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Bronchiectasis**

DUE TO

**Cyst of the Lungs**

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **August 12, 1953** to **August 13, 1953**, that I last saw the deceased alive on **August 13, 1953**, and that death occurred at **8:17 PM**, from the causes and on the date stated above.

23A. SIGNATURE

**R. G. Gindell**

23B. ADDRESS

M. D.

**1400 N. Caroline St.**

23C. DATE SIGNED

**Aug. 13, '53**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**8-18-53**

24C. NAME OF CEMETERY OR CREMATORY

**New Cathedral**

24D. LOCATION (City, town, or county) (State)

**Baltimore, Md.**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**Huntington H. H. H. H.**

25. FUNERAL DIRECTOR

ADDRESS

**Lilly & Zeiler, Inc 403 S. Wolfe Street**

VS 150

2903L

MEDICAL CERTIFICATION



S-610

53 7366

53-19303

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7366

1. NAME OF DECEASED (Type or Print) <b>BABY DOLORES SCHARF</b>		2. DATE OF DEATH <b>8/17/53</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>BON SECOURS HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 28, MD. CATONSVILLE</b>	
C. Length of stay in Baltimore <b>9 days</b>		D. STREET ADDRESS (If rural, give location) <b>124 CHERRYDELL RD.</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>8/7/53</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	9. AGE (in years last birthday) <b>9 days</b>
13. FATHER'S NAME <b>FRANKLIN SCHARF</b>		14. MOTHER'S MAIDEN NAME <b>MARIETTA BUCCI</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>NONE</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>PARENTS</b>		ADDRESS <b>SAME</b>	
18. <b>772.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Malnutrition, dehydration</b> DUE TO <b>Possible lung pathology.</b> (B) _____ DUE TO _____ (C) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Since birth (approx 10 days)</b>			
19. DATE OF OPERATION <b>7</b> 19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>August 16, 1953</b> , to <b>August 17, 1953</b> , that I last saw the deceased alive on <b>August 17, 1953</b> , and that death occurred at <b>8:40 A.M.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Edward J. Byrne</b>		23B. ADDRESS <b>Bon Secours Hosp.</b>	
23C. DATE SIGNED <b>8/17/53</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>Aug 19, 1953</b>	24C. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>	24D. LOCATION (City, town, or county) (State) <b>BALTO., MARYLAND.</b>
25. FUNERAL DIRECTOR <b>George L. Schwab</b>		ADDRESS <b>2101 Frederick</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 18 1953</b>			

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

PLANT INDUSTRY REPORT

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PLANT INDUSTRY REPORT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-352

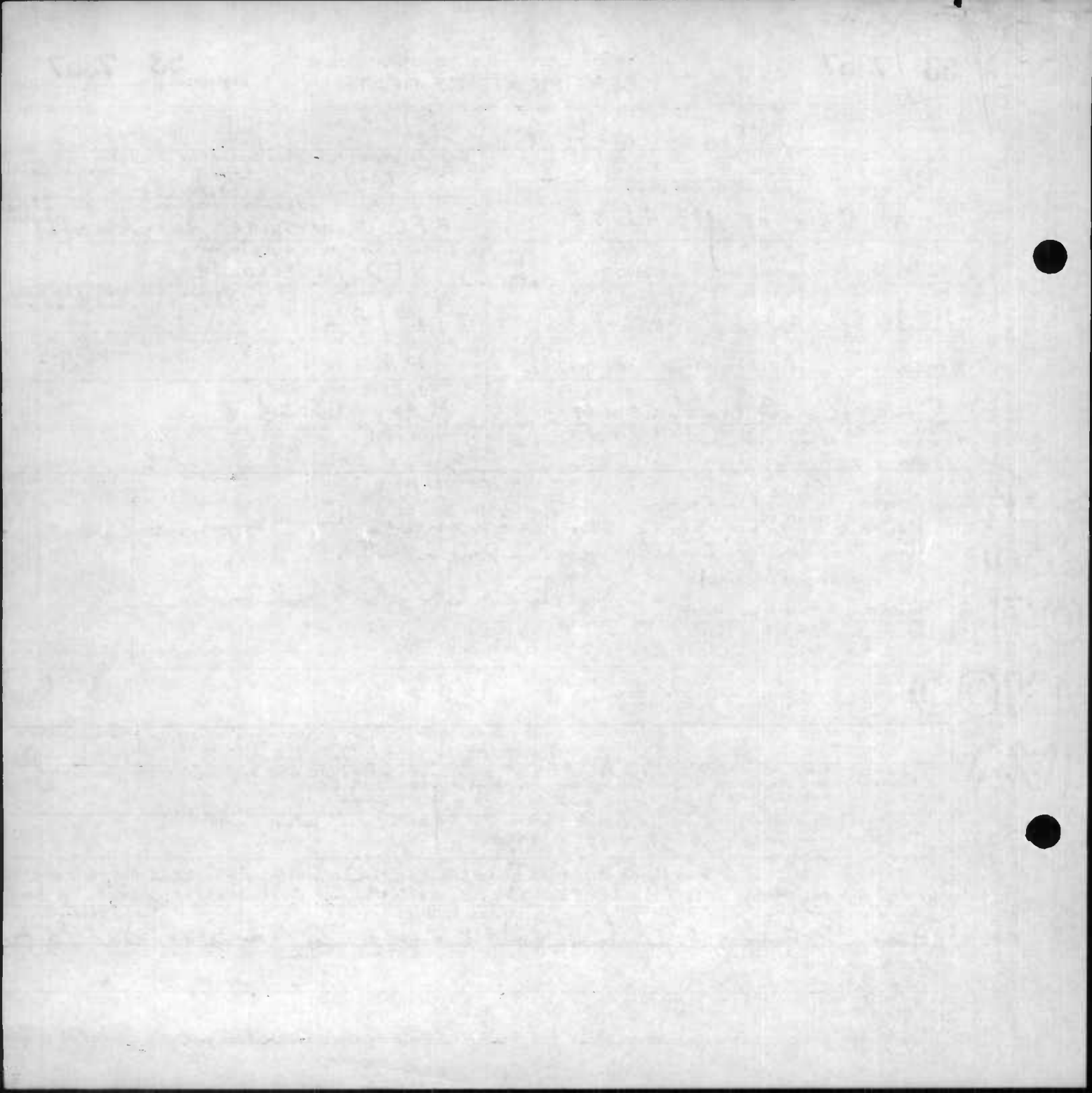
53 7367

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7367

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Stinchcomb, Charles G.		8/14/53	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY A.A.	
B. FULL NAME OF HOSPITAL OR INSTITUTION Univ of Md. Hosp.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) RFD Millersville, Anne Arundel	
C. Length of stay in Baltimore 14 Days		D. STREET ADDRESS (If rural, give location) RFD Millersville 5200	
5. SEX Male	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3/14/93
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator (Ret.)		10B. KIND OF BUSINESS OR INDUSTRY McCormick Teat Spice Co.	9. AGE (In years last birthday) 60
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Stinchcomb		14. MOTHER'S MAIDEN NAME Mary Wood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Raymond Stinchcomb		ADDRESS Millersville Md.	
18. 241X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Emphysema		CAUSE OF DEATH (A) - marked - (B) Bronchial asthma (C)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED 21F. TIME (Month) (Day) (Year) (Hour) OF INJURY		21G. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from Aug 1, 1953 to Aug 14, 1953, that I last saw the deceased alive on Aug 14, 1953 and that death occurred at 11:20 P.M., from the causes and on the date stated above.			
23A. SIGNATURE J. P. R. R. R.		23B. ADDRESS University Hospital	
23C. DATE SIGNED 8/15/53		23D. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.	
23E. LOCATION (City, town, or county) (State) Glen Burnie, Maryland		23F. FUNERAL DIRECTOR Richard V. Singleton	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/18/52	
24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
24E. DATE RECEIVED BY LOCAL REGISTRAR AUG 18 1953		24F. REGISTRAR'S SIGNATURE Huntington	
24G. REGISTRAR'S SIGNATURE Huntington		24H. ADDRESS Glen Burnie Md	





T-512

53 7368

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7368  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>Nellie Virginia Thompkins</b>		2. DATE OF DEATH <b>Aug. 15, 1953</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1619 S. Charles St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>23-02</b>	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>1619 S. Charles St.</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>2/24/1873</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	9. AGE (In years last birthday) <b>80</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George Callahan</b>		14. MOTHER'S MAIDEN NAME <b>Susan Ann Pinkine</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Mrs. Olive Sands</b>		ADDRESS <b>1619 S. Charles St.</b>	
18. <b>421.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Chronic Endocarditis</b> DUE TO <b>General Anasarca</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>6 mos.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 7</b> , 19 <b>52</b> , to <b>Aug 15</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>Aug 14</b> , 19 <b>53</b> , and that death occurred at <b>10:00 Am.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>W. H. H. H. H. H.</b>		23B. ADDRESS <b>1279 Williams St.</b>	
23C. DATE SIGNED <b>8/17/53</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Aug. 18, '53</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	24D. LOCATION (City, town, or county) (State) <b>Ritchie Hgwy.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>Aug 18 1953</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams</b>	25. FUNERAL DIRECTOR <b>John F. Denby, Inc.</b>	
		ADDRESS <b>715 Light St.</b>	

STATE OF MARYLAND  
Baltimore City  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Occupation		Education		Medical History		Post-mortem Examination	
Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness	
Signature of Deceased		Signature of Next of Kin		Signature of Burial Officer		Signature of Interment Officer	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-256

53 7369

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7369

1. NAME OF DECEASED (Type or Print) <b>MATILDA HAUSNER</b>		2. DATE OF DEATH <b>Aug. 15, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>none</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Southern Hospital &amp; Home</b> <b>2520 Greenmount Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore St.</b> <b>21-01</b>	
c Length of stay in Baltimore <b>70</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>611 Scott St.</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>May 8, 1875</b>
9. AGE (In years last birthday) <b>78</b>		10. Under 1 Year Months: Days	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Jacob G. Haug</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Irion</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Records, Southern Home</b>		ADDRESS <b>2520 Greenmount Ave</b>	
18. <b>420.1</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> DUE TO <b>Hypertension</b> DUE TO <b>Hypertension</b> DUE TO <b>Hypertension</b>			INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Jan 1950</b> to <b>Aug 15, 1953</b> that I last saw the deceased alive on <b>Aug 15, 1953</b> and that death occurred at <b>21</b> m., from the causes and on the date stated above.			
23A. SIGNATURE <b>M. Ephraim</b>		23B. ADDRESS <b>443 E. 25th St.</b>	23C. DATE SIGNED <b>8.17.53</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8 - 18 - 53</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Louisa National</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 18 1953</b>	REGISTRAR'S SIGNATURE <b>H. H. 255</b>	25. FUNERAL DIRECTOR <b>John G. Mitchell &amp; Sons Inc.</b>	
ADDRESS <b>-1900 Eutaw Pl.</b>		VS 150	

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H-650

53 7370

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7370

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ROSE MARY HROMEY

2. DATE  
OF  
DEATH

AUG. 16-1953

3. PLACE OF DEATH:  
A. Baltimore City, MarylandB. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION 625 S. Hecker Ave.4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)  
A. STATE Md B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)  
Balto 1-02C. Length of stay in Baltimore Life Yrs.  
Mos.  
DaysD. STREET ADDRESS (If rural, give location)  
625 S. Hecker Ave.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Sept 8-1908

9. AGE (in years  
last birthday)

44

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

at Home

11. BIRTHPLACE (State or foreign country)

Balto, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Malczewski

14. MOTHER'S MAIDEN NAME

Francis Werczycki

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

216-01-0595

17. INFORMANT

Mr. John Hromej - 625 S. Hecker

ADDRESS

18. 170X I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) CANCER OF LEFT BREAST

DUE TO

4 1/2

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from AUG. 5, 1953, to AUG. 16, 1953, that I last saw the  
deceased alive on AUG. 10, 1953, and that death occurred at 11:20 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEPARTMENT OF HEALTH  
OFFICE OF VITAL RECORDS  
STATE OF NEW YORK

CAUSE OF DEATH



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-425		BALTIMORE CITY HEALTH DEPARTMENT		53-7371	
BIRTH NO. 53 7371		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <i>Carrie E. Wilson</i>			2. DATE OF DEATH <i>8/16/53 1:30 am</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>336 E. Belvedere Ave</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto. 27-12</i>		
C. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>336 E. Belvedere Ave</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>9/24/1876</i>	9. AGE (In years last birthday) <i>76</i>	10. Under 1 Year Months: Days <i>10 22</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <i>Geo. Heise</i>		
14. MOTHER'S MAIDEN NAME <i>Margaret (Unknown)</i>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <i>Stanley Wilson 2551 Kirk Ave</i>		
18. <i>422.1 and 260X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH <i>Chronic Myocarditis</i> DUE TO <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO <i>Rickettsia mellitus.</i>		
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>Sept. 10</i> , 1950, to <i>Aug. 16</i> , 1953, that I last saw the deceased alive on <i>Aug. 15</i> , 1953, and that death occurred at <i>m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Howard B. Mink</i>			23B. ADDRESS <i>1321 E. North Ave</i>		23C. DATE SIGNED <i>8-17-53</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>8/19/53</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Cathedral</i>	24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 18 1953</i>			REGISTRAR'S SIGNATURE <i>Huntington Williams</i>		25. FUNERAL DIRECTOR ADDRESS <i>Wm. Cook &amp; Co. 1217 St. Paul St.</i>

NEW YORK

RECEIVED

STATE OF NEW YORK

NOV 28

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

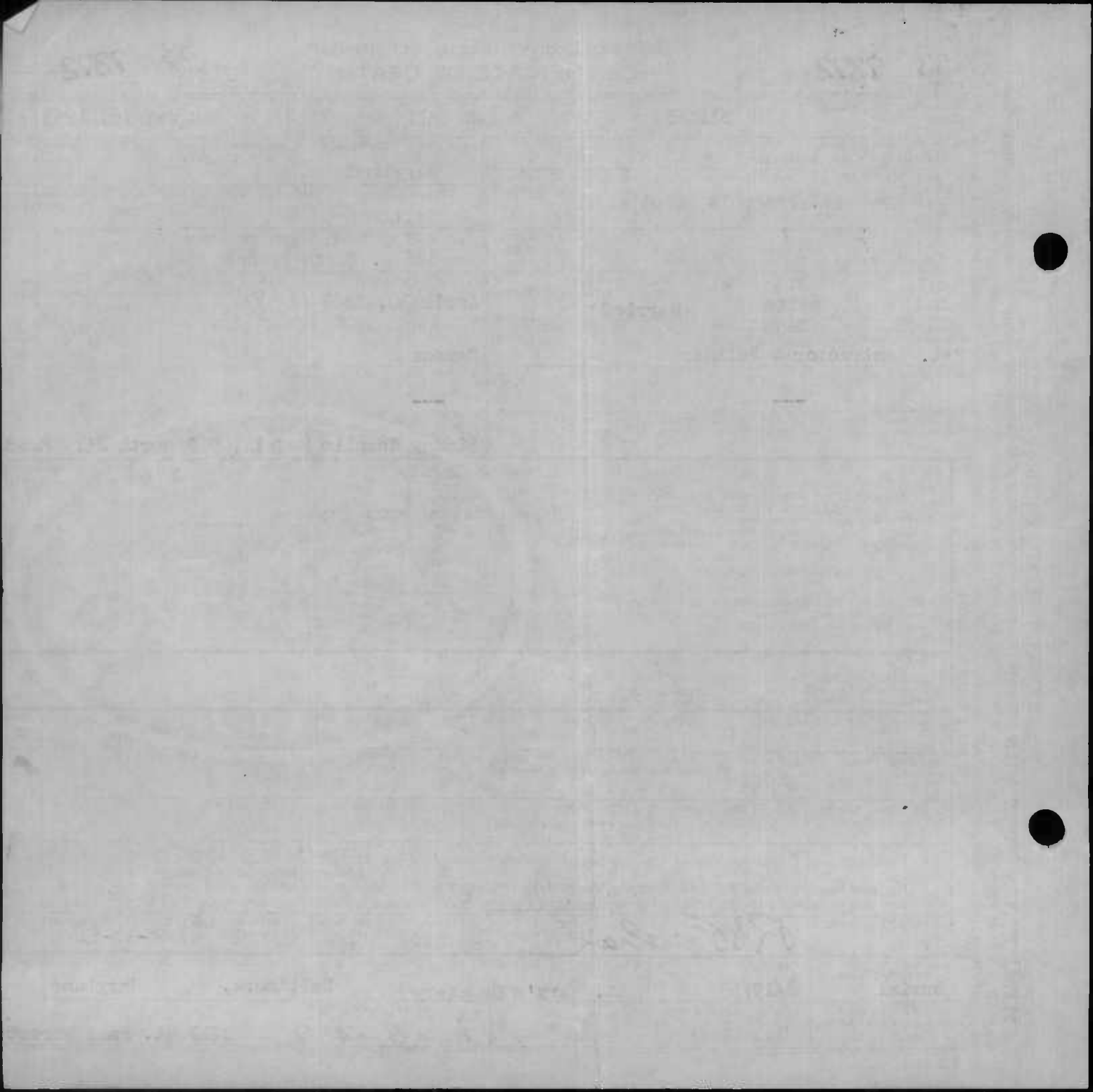
M-240

53 7372

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7372

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		SIDNEY MC CALL		2. DATE OF DEATH August 16, 1953	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland			
B. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-08			
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____				D. STREET ADDRESS (If rural, give location) 826 E. North Avenue			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 30, 1867		9. AGE (in years last birthday) 86	If Under 1 Year Months _____ Days _____	If Under 24 Hours Hours _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Contractor & Builder			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME ---			14. MOTHER'S MAIDEN NAME ---				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Sidney Rozelle McCall, 969 North Hill Road			
18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertensive Heart Disease (A) <del>XXXX</del>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an inspection & inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
23A. SIGNATURE R. B. Fisher		23B. CHIEF MEDICAL EXAMINER... ASSISTANT MEDICAL EXAMINER... MEDICAL INVESTIGATOR... M.D. 8-17-53		23C. DATE SIGNED 8-17-53			
24A. BURIAL, CREMATION, REMOVAL (Specify) burial		24B. DATE 8/19/53		24C. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE Huntington Williams		25. FUNERAL DIRECTOR H. M. Book, Inc.		ADDRESS 1217 St. Paul Street	









8-235

53 7374

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7374

1. NAME OF DECEASED (Type or Print) <i>Henry A. Pozdena</i>			2. DATE OF DEATH <i>Aug 16 1953</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1-02</i>		
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>2923 Eastern ave</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>		
Length of stay in Baltimore <i>32 years</i>			D. STREET ADDRESS (If rural, give location) <i>2923 Eastern ave</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>July 29 1895</i>	9. AGE (In years last birthday) <i>58</i>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman selling shoes</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Adam Dym (ca)</i>		
11. BIRTHPLACE (State or foreign country) <i>Germany</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Leo Pozdena</i>			14. MOTHER'S MAIDEN NAME <i>Ida Schwartz</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)			16. SOCIAL SECURITY NO. <i>213-12-0105</i>		
17. INFORMANT <i>Mary Dolores Pozdena</i>			ADDRESS <i>2923 Eastern ave</i>		

18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Thrombosis</i> (A) DUE TO	CAUSE OF DEATH <i>Generalized Atherosclerosis</i> (B) DUE TO	INTERVAL BETWEEN ONSET AND DEATH <i>Immediately</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>0</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *8/3/53*, 19*53*, to *8/16/53*, 19*53*, that I last saw the deceased alive on *8/10*, 19*53*, and that death occurred at *8 P.* m. from the causes and on the date stated above.

23A. SIGNATURE <i>Rebecca Lefun</i>	23B. ADDRESS <i>1261 E. Mt. St.</i>	23C. DATE SIGNED <i>8-17-53</i>
--	--	------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Aug 19/53</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn</i>	24D. LOCATION (City, town, or county) (State) <i>Balt. County</i>
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DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 18 1953</i>	REGISTRAR'S SIGNATURE <i>Huntington Wilson</i>	25. FUNERAL DIRECTOR <i>John M. Weber</i>	ADDRESS <i>401 S. Chester</i>
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NOT

NOT

NOT



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-520

53 7375

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7375

Registered No.

BIRTH NO

1. NAME OF DECEASED  
(Type or Print)

Mary Stines

2. DATE  
OF  
DEATH

Aug 16 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Osl 3

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md. 2-02

8. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2118 E. Federal St.

e. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

1-27-1883

9. AGE (In years  
last birthday)

70

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Julius Berkmaier

14. MOTHER'S MAIDEN NAME

Josephine Birkhoff

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.17. INFORMANT  
JOHNS HOPKINS HOSPITAL

ADDRESS

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Myocardial infarction

1 week

ANTECEDENT CAUSES

(B) DUE TO

arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/9, 1953 to 8/16, 1953, that I last saw the  
deceased alive on 8/16, 1953, and that death occurred at 7:00 PM., from the causes and on the date stated above.

23A. SIGNATURE

Lawrence L. Cheef

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

8/16/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

25. FUNERAL DIRECTOR

ADDRESS

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RECEIVED BY THE OFFICE OF THE

COMMISSIONER OF DEATH

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RECEIVED BY THE OFFICE OF THE

COMMISSIONER OF DEATH

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7376

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7376  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ROSE STEPANEK

2. DATE  
OF  
DEATH

Aug 16, 1953

3. PLACE OF DEATH

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

4207 Kolb Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

27-09

D. STREET ADDRESS (If rural, give location)

4426 Marble Hall Road

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Nov. 9, 1896

9. AGE (In years  
last birthday)

56

It Under 1 Year  
Months: DaysIt Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Stenographer

10B. KIND OF BUSINESS OR  
INDUSTRY

Health Dept.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Stepanek

14. MOTHER'S MAIDEN NAME

Josephine Picka

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS

Mrs. Mary Krakora 4207 Kolb Ave.

18.

231X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Cerebral Hemorrhage

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)Hypertension  
ArteriosclerosisINTERVAL BETWEEN  
ONSET AND DEATH

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21a. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 16 August, 1953, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the  
deceased alive on 8/16, 1953, and that death occurred at 1:50 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Martin W. Krupp

23B. ADDRESS

4207 Kolb Ave #6

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug 19, 1953

24C. NAME OF CEMETERY OR CREMATORY

Oak Hill Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

H. Sander &amp; Sons, Inc.

ADDRESS

Baltimore, Maryland

AUG 18 1953

VS 150

350 93

Sgt. A. Sander

25 1978

25 1978



N-230  
53 7377

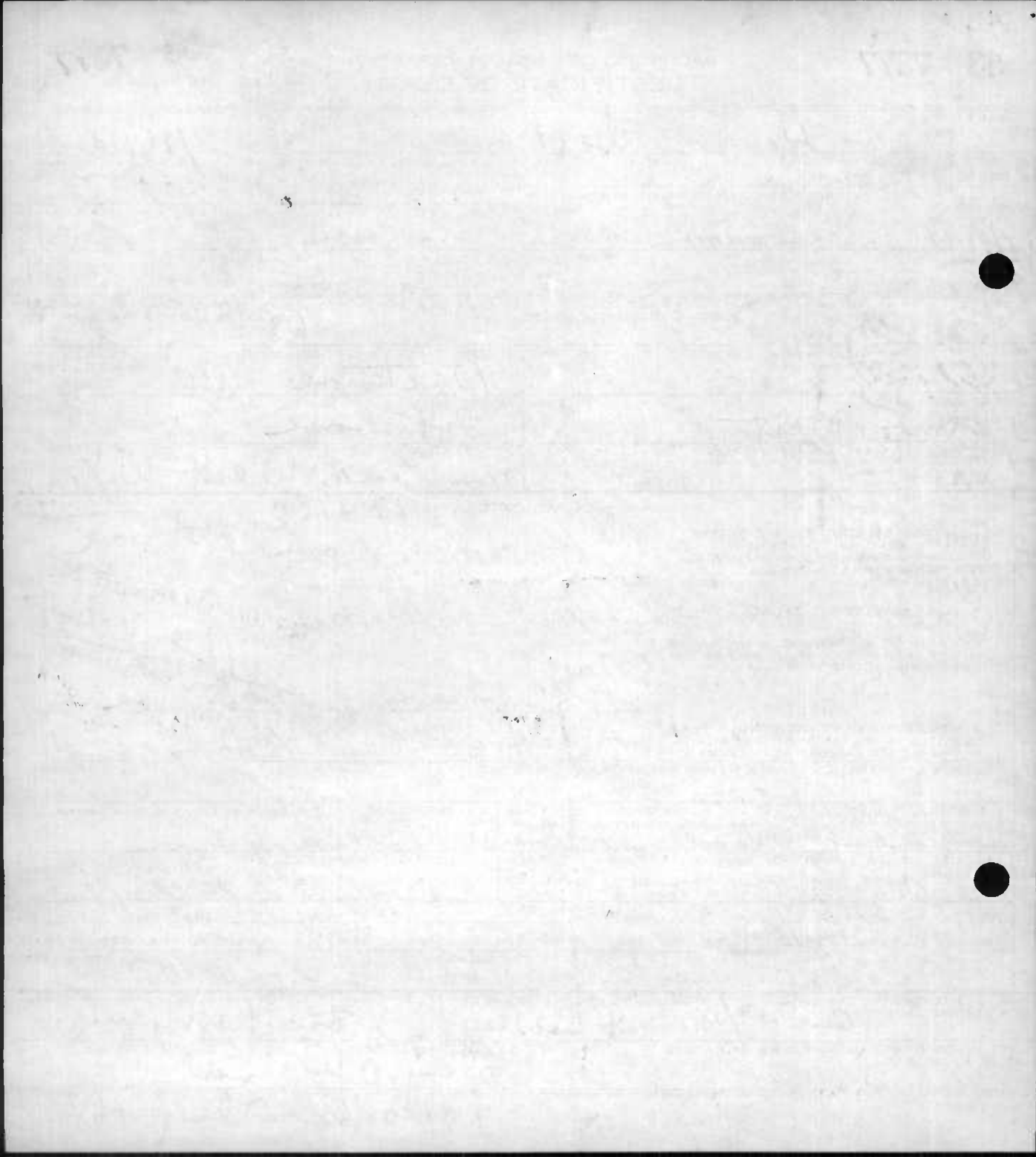
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7377  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Howard West</b>		2. DATE OF DEATH <b>8/16/53</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>			
b. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Bar-Hill-Ba Convalescent Home - 2101 Coldspring Lane</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>			
c. Length of stay in Baltimore		d. STREET ADDRESS (If rural, give location) <b>2101 Coldspring Lane</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	9. AGE (In years last birthday) <b>68</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore MD</b>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>James West</b>		14. MOTHER'S MAIDEN NAME <b>not known</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Ida West wife</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>181X and E 903.7</b>		CAUSE OF DEATH <b>1241. E - Federal</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b>		(A) <b>Myocardial Failure</b> DUE TO		CERTIFICATION APPROVED BY <b>J. J. Jackson</b> CHIEF OF ASS. MEDICAL EXAMINER.	
(B) <b>Hypostatic Pneumonia</b> DUE TO		(C) <b>Malignancy of Bladder</b>		<b>1 yr.</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Fractured Right Humerus</b>		<b>10 days</b>	
19a. DATE OF OPERATION <b>0</b>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>contributing</b>	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>convalescent home 2101 Coldspring Lane</b>	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>while walking</b>			
21d. TIME (Month) (Day) (Year) (Hour) <b>Aug. 1953</b>	21e. INJURY OCCURRED <b>while walking</b>	21f. HOW DID INJURY OCCUR? <b>he slipped to the floor</b>			
22. I hereby certify that I attended the deceased from <b>Feb.</b> , 1952, to <b>Aug. 15</b> , 1953, that I last saw the deceased alive on <b>Aug. 15</b> , 1953, and that death occurred at <b>7 a. m.</b> , from the causes and on the date stated above.					
23a. SIGNATURE <b>Guthrie L. Bumpers</b>		23b. ADDRESS <b>722 N. Fulton Ave</b>		23c. DATE SIGNED <b>8/16/53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>Aug 19th/53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>mt Calvary</b>	24d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>		
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <b>Huntington</b>	25. FUNERAL DIRECTOR <b>Oliver O Wilson</b>		ADDRESS <b>97099 1000 Brantley AV</b>	

MEDICAL CERTIFICATION

VS 150  
N-820.0



E-400

53 7378

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7378

1. NAME OF DECEASED (Type or Print) <b>AGNES LUCAS ELY</b>		2. DATE OF DEATH <b>8-15-53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Provident Hosp.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>17-03</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital - Free Dispensary</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Bolts Maryland</b>	
D. STREET ADDRESS (If rural, give location) <b>621 N Fremont Ave.</b>		5. SEX <b>female</b>	
6. COLOR OR RACE <b>colored</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	
8. DATE OF BIRTH <b>June 27, 1882</b>		9. AGE (In years last birthday) <b>71 yrs.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>sewnaplayer</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. FATHER'S NAME <b>Thomas Ely</b>		12. CITIZEN OF WHAT COUNTRY?	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <b>Fannie Robinson</b>	
15. SOCIAL SECURITY NO.		16. INFORMANT ADDRESS	

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>congestive heart failure</b>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>hypertensive heart disease</b>		
DUE TO		
(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7-28-53</b> , 19 <b>53</b> , to <b>8-15-53</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>8-15-53</b> , 19 <b>53</b> , and that death occurred at <b>3:20 pm</b> from the causes and on the date stated above.					
23A. SIGNATURE <b>Leonard T. Harris</b>		23B. ADDRESS <b>Provident Hospital</b>		23C. DATE SIGNED	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/17/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>		24E. LOCAL REGISTRAR <b>Huntington W. Harris</b>		24F. FUNERAL DIRECTOR <b>Chas. O. Wilson</b>	
24G. DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 18 1953</b>		24H. REGISTRAR'S SIGNATURE <b>Huntington W. Harris</b>		24I. ADDRESS <b>1000 Brantly Ave</b>	

1-12-58

DECEASED

NAME

DATE OF BIRTH

SEX

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

REPORTED BY

RELATIONSHIP TO DECEASED

DATE OF REPORT

SIGNATURE

REPORTED BY

DATE OF REPORT

REPORTED BY

53 7379

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7379  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Robert Johnson

2. DATE  
OF  
DEATH

Aug 16, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Med. Dept. 2

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore

7 Yrs.

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

12-23-77

9. AGE (In years,  
last birthday)

75

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR  
INDUSTRY

All Kinds

11. BIRTHPLACE (State or foreign country)

Manning S.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jim Johnson

14. MOTHER'S MAIDEN NAME

Martha Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18.

420.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Arterio Digitalis Intoxication

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Arterio Sclerotic Heart Disease

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-14-53 to 8-16-53, that I last saw the  
deceased alive on 8-16-53, and that death occurred at 8:25 p.m. from the causes and on the date stated above.

23A. SIGNATURE

W. Gordon Walker

M. D.

23B. JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

16 August 1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8/20/1953

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary Cem.

24D. LOCATION (City, town, or county)

Brooklyn Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Elmer D. Wilson 1108 Bently

2178

2179

REPUBLICAN PARTY  
OFFICE OF THE SECRETARY  
WASHINGTON, D. C.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

F. 610		BALTIMORE CITY HEALTH DEPARTMENT		53 7380	
53 7380		173380 AJX		Registered No. 53 7380	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Essie Mae Ferby</b>			2. DATE OF DEATH <b>8-14-53</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Bethesda, City</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Baltimore City Hospital</b> <b>4940 Eastern Ave</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>3-01</b>		
c. Length of stay in Baltimore <b>26yrs</b>			D. STREET ADDRESS (If rural, give location) <b>400 S. Dallas</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>July 26 1909</b>	9. AGE (In years last birthday) <b>44</b>	If Under 1 Year Months Days If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>operator</b>			11. BIRTHPLACE (State or foreign country) <b>Va.</b>		
10B. KIND OF BUSINESS OR INDUSTRY <b>factory</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Alex German</b>			14. MOTHER'S MAIDEN NAME <b>Francis Anderson</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT (Records) <b>4940 Eastern Ave</b>			ADDRESS <input checked="" type="checkbox"/>		
18. <b>416X</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Rheumatic Heart Disease</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>8-13-53</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>8-13-53</b> , 19__, to <b>8-14-53</b> , 19__, that I last saw the deceased alive on <b>8-14-53</b> , 19__, and that death occurred at <b>9:50am</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>H. J. Williams</b>		23B. ADDRESS <b>4940 Eastern Ave</b>		23C. DATE SIGNED <b>8-14-53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>8-17-53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary Cem</b>	
24D. LOCATION (City, town, or county) (State) <b>Brooklyn Md</b>		24E. FUNERAL DIRECTOR <b>W. J. Williams</b>		24F. ADDRESS <b>1010</b>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR	
VS 150		6904Y			

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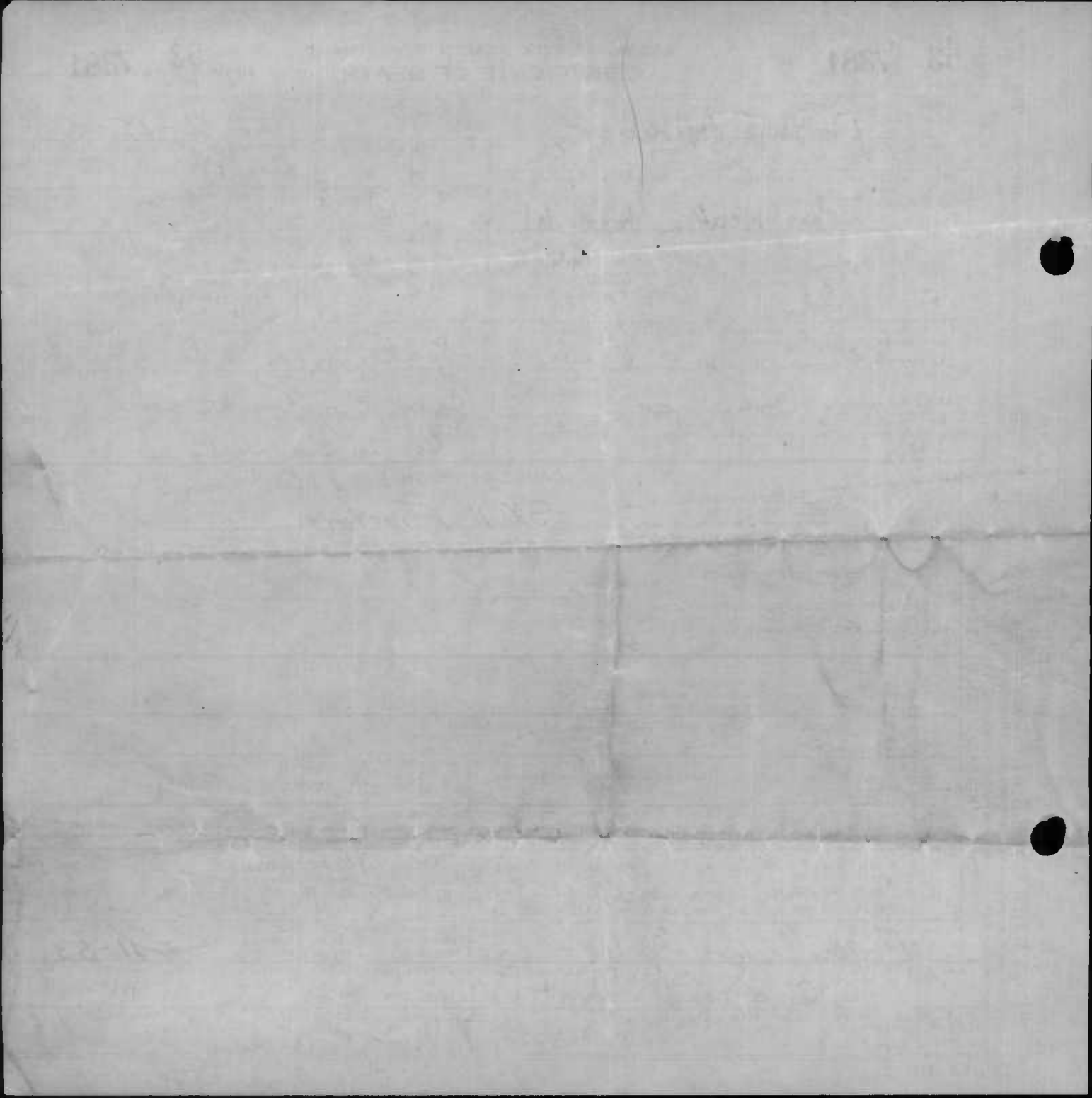
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A-453  
53 7381BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7381  
Registered No. 7381

BIRTH NO.				2. DATE OF DEATH 8-15-53			
1. NAME OF DECEASED (Type or Print) Dorothy Allendor				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City				A. STATE Maryland			
B. FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital				C. CITY OR TOWN Baltimore 5-02			
c. Length of stay in Baltimore Born in Balto. Yrs. Mos. Days				D. STREET ADDRESS (If rural, give location) 1118 Orleans St			
5. SEX F	6. COLOR OR RACE Gre	7. SINGLE/MARRIED. WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	9. AGE (In years last birthday) 25	10. Under 1 Year Months Days	11. Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Anderson				14. MOTHER'S MAIDEN NAME Francis Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) JW		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Thomas Weems			
18. E 8164 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH 1118 Orleans St			
(A) SKULL FRACTURE				DUE TO			
ANTECEDENT CAUSES				(B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				DUE TO			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Fairmount Avenue & Ann Street 6/5			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 8-15-53 9:40 P.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? passenger in auto & auto collision			
22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
23A. SIGNATURE William Anderson				23B. CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER MEDICAL INVESTIGATOR		23C. DATE SIGNED 8-16-53	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE Aug 18th/53		24C. NAME OF CEMETERY OR CREMATORY Mt Calvary		24D. LOCATION (City, town, or county) (State) Brooklyn Md	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR		ADDRESS	
AUG 18 1953		Huntington Williams		E. Livingston Wilson		1000 Brantley Ave	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A-252 CERTIFICATE CORRECTED				BALTIMORE CITY HEALTH DEPARTMENT		8-16-53	
103 7382				BIRTH NO.		Registered No. 53 7382	
1. NAME OF DECEASED (Type or Print) <b>Edward Houchins</b>				2. DATE OF DEATH <b>8-16-53</b>			
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>+</b>			
B. FULL NAME OF (not in hospital or institution, give street address or location) <b>South Baltimore General</b>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 25-04</b>			
c. Length of stay in Baltimore Yrs. Mos. Days				D. STREET ADDRESS (If rural, give location) <b>904 Honaker Ct</b>			
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>S</b>	8. DATE OF BIRTH <b>12.9.37</b>		9. AGE (In years last birthday) <b>15</b>	If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School boy</b>				10a. KIND OF BUSINESS OR INDUSTRY <b>BEN FRANKLIN</b>		11. BIRTHPLACE (State or foreign country) <b>W. VA.</b>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <b>None</b>			
14. MOTHER'S MAIDEN NAME <b>MAE Lilly</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>NONE</b>				17. INFORMANT <b>FAMILY SAME</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>E919.01</b> <b>Gunshot wound of Abdomen</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>involving Liver &amp; Aorta -</b> <b>Massive Hemorrhage</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>904-Honaker-Court 820 Glade Court 25-04</b>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>8-16-53 1:20 A.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>shot by friend while playing with rifle</b>			
22. I certify that I took charge of the remains described above, held an <b>Autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .							
23A. SIGNATURE <b>William V. ...</b>				23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. <b>8-16-53</b>		23C. DATE SIGNED	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>15.</b>		24B. DATE <b>8-20-53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Hoochins</b>		24D. LOCATION (City, town, or county) (State) <b>Hunters W. Va.</b>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <b>...</b>		25. FUNERAL DIRECTOR <b>...</b>			
ADDRESS <b>130 E. FORT AVE.</b>							





B-650

83

53 7883

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 53 7883

1. NAME OF DECEASED (Type or Print) <i>HELEN G. BROWN</i>		2. DATE OF DEATH <i>8.17.53</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>3811 2nd St.</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>25-04</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>BALTIMORE</i>	
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <i>3811 2nd Ave.</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>M.</i>	8. DATE OF BIRTH <i>3.26.09</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWORK</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13. FATHER'S NAME <i>JAMES W. JONES</i>		14. MOTHER'S MAIDEN NAME <i>JENNIE V. PETER</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>NO</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Family</i>		ADDRESS <i>SAME</i>	
18. <i>445X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Memia</i> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>malpait Hypertension</i> DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>March</i> , 19 <i>53</i> , to <i>8-17</i> , 19 <i>53</i> that I last saw the deceased alive on <i>8-16</i> , 19 <i>53</i> and that death occurred at <i>9:46</i> m., from the causes and on the date stated above.			
23A. SIGNATURE <i>M. M. M. M.</i>		23B. ADDRESS <i>4046 Nichols Unit</i>	
23C. DATE SIGNED <i>8-17-53</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <i>8.20.53</i>	24C. NAME OF CEMETERY OR CREMATORY <i>St. Louis</i>	24D. LOCATION (City, town, or county) (State) <i>FAITH N.C.</i>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <i>Huntington H. B. B. B.</i>	25. FUNERAL DIRECTOR (Name) <i>L. L. L. L.</i>	
ADDRESS <i>130 E. Fort Ave.</i>			

MEDICAL CERTIFICATION

88

CONFIDENTIAL

100



22

N. 160

53 7384

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7384

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOHN JOHN NEUBAUER</b>			2. DATE OF DEATH <b>AUG 16, 1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>3406 E. PRATT</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
5. FULL NAME OF HOSPITAL OR INSTITUTION			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>26-08</b>		
6. LENGTH OF STAY IN BALTIMORE <b>60 - Yrs.</b>			D. STREET ADDRESS (If rural, give location) <b>3406 E. PRATT ST</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>AUG 26, 1876</b>	9. AGE (In years last birthday) <b>76</b>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BLACK SMITH - RET.</b>			11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		
13. FATHER'S NAME <b>? NEUBAUER</b>			14. MOTHER'S MAIDEN NAME <b>DONT KNOW</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>MRS CATHERINE LOEPFLER E. PRATT</b>			ADDRESS <b>3406</b>		

18. <b>331X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRAL HEMORRHAGE</b>	CAUSE OF DEATH <b>CEREBRAL HEMORRHAGE</b>	INTERVAL BETWEEN ONSET AND DEATH <b>2 dys.</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>ARTERIOSCLEROSIS. GENERALIZED</b>	(B) <b>ARTERIOSCLEROSIS. GENERALIZED</b>	<b>5-10 yrs.</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>GOVT</b>	(C) <b>GOVT</b>	<b>5-10 yrs.</b>

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **20 JAN.**, 19**51**, to **16 AUG.**, 19**53**, that I last saw the deceased alive on **16 AUG.**, 19**53** and that death occurred at **1230 P.M.**, from the causes and on the date stated above.

23A. SIGNATURE <b>Benjamin Doherty</b>	23B. ADDRESS <b>121 S. HIGHLAND AVE.</b>	23C. DATE SIGNED <b>8/16/53</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>AUG 26, 1953</b>	24C. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>
24D. LOCATION (City, town, or county) (State) <b>COLGATE MD</b>	25. FUNERAL DIRECTOR ADDRESS <b>2112</b> <b>ULLEBRICH RUMERAU HOME DUNDBLCK</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 15 1953</b>		

MEDICAL CERTIFICATION

60-2 26

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

VALLEY

COOPER

STREET

NEW YORK

CITY

1910

1911

1912

1913

1914

1915

53 7385

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7385  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARY STERLING GREEN

2. DATE  
OF  
DEATH

8/16/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR INSTITUTION 1102 STODDARD PLACE location)C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
BALTIMORE township)

c. Length of stay in Baltimore

LIFE

D. STREET ADDRESS (If rural, give location)

1102 STODDARD CT.

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
WIDOWED

8. DATE OF BIRTH

3/5/1888

9. AGE (In years  
last birthday)

65

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR  
INDUSTRY

DOMESTIC

11. BIRTHPLACE (State or foreign country)

BALTO. MD

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

RICHARD DYER

14. MOTHER'S MAIDEN NAME

CAROLINE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

NO

16. SOCIAL  
SECURITY NO.

NONE

17. INFORMANT

ADDRESS

CHARLES STERLING(S) 1102 STODDARD

18. 422.2

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Chronic Myocarditis  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) DUE TO  
(C)INTERVAL BETWEEN  
ONSET AND DEATHHistory  
IndefiniteII  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1913, to Aug 16, 1953, that I last saw the  
deceased alive on Aug 15, 1953, and that death occurred at 8 P. m., from the causes and on the date stated above.

23A. SIGNATURE

G. Garland Chiswell

M. D.

23B. ADDRESS

1534 David Hill Ave

23C. DATE SIGNED

Aug 18

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

8/2 0/53

24C. NAME OF CEMETERY OR CREMATORY

MT. AUBURN CEMETERY

24D. LOCATION (City, town, or county)

BALTO. MD.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

CHARLES G. COOPER-512 CARROLLTON

ADDRESS

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-452

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. <u>53 7386</u>	
1. NAME OF DECEASED (Type or Print) <u>Baby Williams</u>			2. DATE OF DEATH <u>8 12 53</u>		
3. PLACE OF DEATH: A. <u>Baltimore City, Maryland Baltimore md</u> B. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Agnes Agnes</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Ma</u> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore Md 12-06</u> D. STREET ADDRESS (If rural, give location) <u>3037 Remington Ave</u>		
5. SEX <u>Boy</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>8 12 53</u>	9. AGE (In years last birthday) <u>30</u>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>James Williams</u>			14. MOTHER'S MAIDEN NAME <u>Mary J. M. Donald</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>James Williams 3037 Remington Ave</u>		
18. <u>774X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH <u>5 month preg - abortion</u>  INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		19C. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8-12</u> , 19 <u>53</u> , to <u>8-12</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>8-12</u> , 19 <u>53</u> , and that death occurred at <u>m.</u> , from the causes and on the date stated above.					
23A. SIGNATURE <u>John Colin Ryan M.D.</u>		23B. ADDRESS <u>St Agnes Hosp</u>		23C. DATE SIGNED <u>8-12-53</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <u>Aug 18/53</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lincoln C</u>	
24D. LOCATION (City, town, or county) (State) <u>Bald</u>					
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR ADDRESS <u>William J. Horn 1122 Donald St</u>	

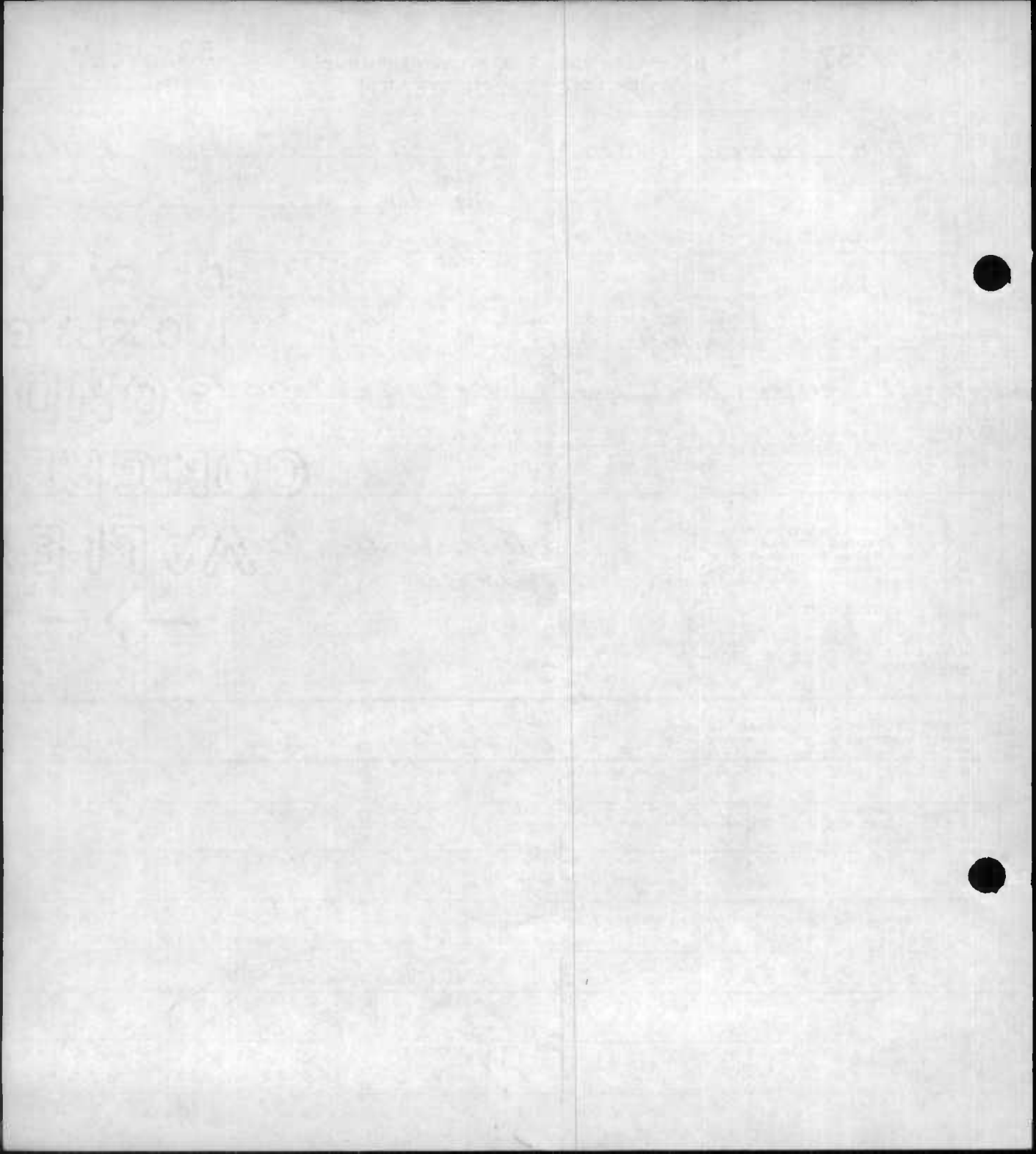
Wm. W. Brown  
James W. Brown

Wm. W. Brown  
James W. Brown

W-425  
53 7387BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7387  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Harry Thomas Wilson Sr.</b>		2. DATE OF DEATH <b>August 18, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <b>6003 FALKIRK RD.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 22-38</b>	
C. Length of stay in Baltimore Yrs. <b>22</b> Mos. <b>38</b> Days <b>0</b>		D. STREET ADDRESS (If rural, give location) <b>6003 Falkirk Road</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Feb. 17-1883</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lieutenant Baltimore Police Dept.</b>		9. AGE (in years last birthday) <b>70</b> If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.	
10B. KIND OF BUSINESS OR INDUSTRY <b>Ret.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>	
13. FATHER'S NAME <b>JAMES HENRY WILSON</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <b>MARY NORTON</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Dr. HARRY T. Wilson - Edgewood</b> ADDRESS <b>1825</b>	
18. <b>420.0 and 260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic heart disease</b> CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>Indef.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Diabetes Mellitus</b>			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>August 1951</b> , to <b>August 18, 1953</b> , that I last saw the deceased alive on <b>August 11, 1953</b> , and that death occurred at <b>6:30 a.m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Robert E. May</b> M. D.		23B. ADDRESS <b>1200 Woodbourne Av.</b>	
23C. DATE SIGNED <b>8/18/53.</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>Aug. 21-1953</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO MD</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>15 18 1953</b>		REGISTRAR'S SIGNATURE <b>Wilmington</b>	
25. FUNERAL DIRECTOR <b>Leonard J. Ruck</b>		ADDRESS <b>5305 Bayford Rd</b>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7388  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Alexander Gregorovich GREGOROWICH.

2. DATE  
OF  
DEATH

8-16-1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Baltimore City Hospitals  
4940 Eastern Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1009 S. Kenwood Ave. zone 24

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

JUNE 21, 1882

9. AGE (In years

last birthday)

71

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

FISHER BODY CO.

11. BIRTHPLACE (State or foreign country)

POLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

? GREGOROWICH

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

NO

16. SOCIAL SECURITY NO.

NO

17. INFORMANT

4940 Eastern Ave. Records: Baltimore City Hospitals

18.

180X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Carcinoma

DOE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypernephroma Bilateral

DOE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

July 28-1953

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Angiocardiogram

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-8, 1953, to 8-16, 1953 that I last saw the deceased alive on 8-16, 1953, and that death occurred at 8.30A.m., from the causes and on the date stated above.

23A. SIGNATURE

H. J. Miller

23B. ADDRESS

4940 Eastern Ave., Baltimore, Md.

23C. DATE SIGNED

8-17-1953

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

8-19-53

24C. NAME OF CEMETERY OR CREMATORY

ST. STANISLAUS CEM.

24D. LOCATION (City, town, or county)

1300 DUNDALK AVE. BALTO.

DATE RECEIVED BY LOCAL REGISTRAR

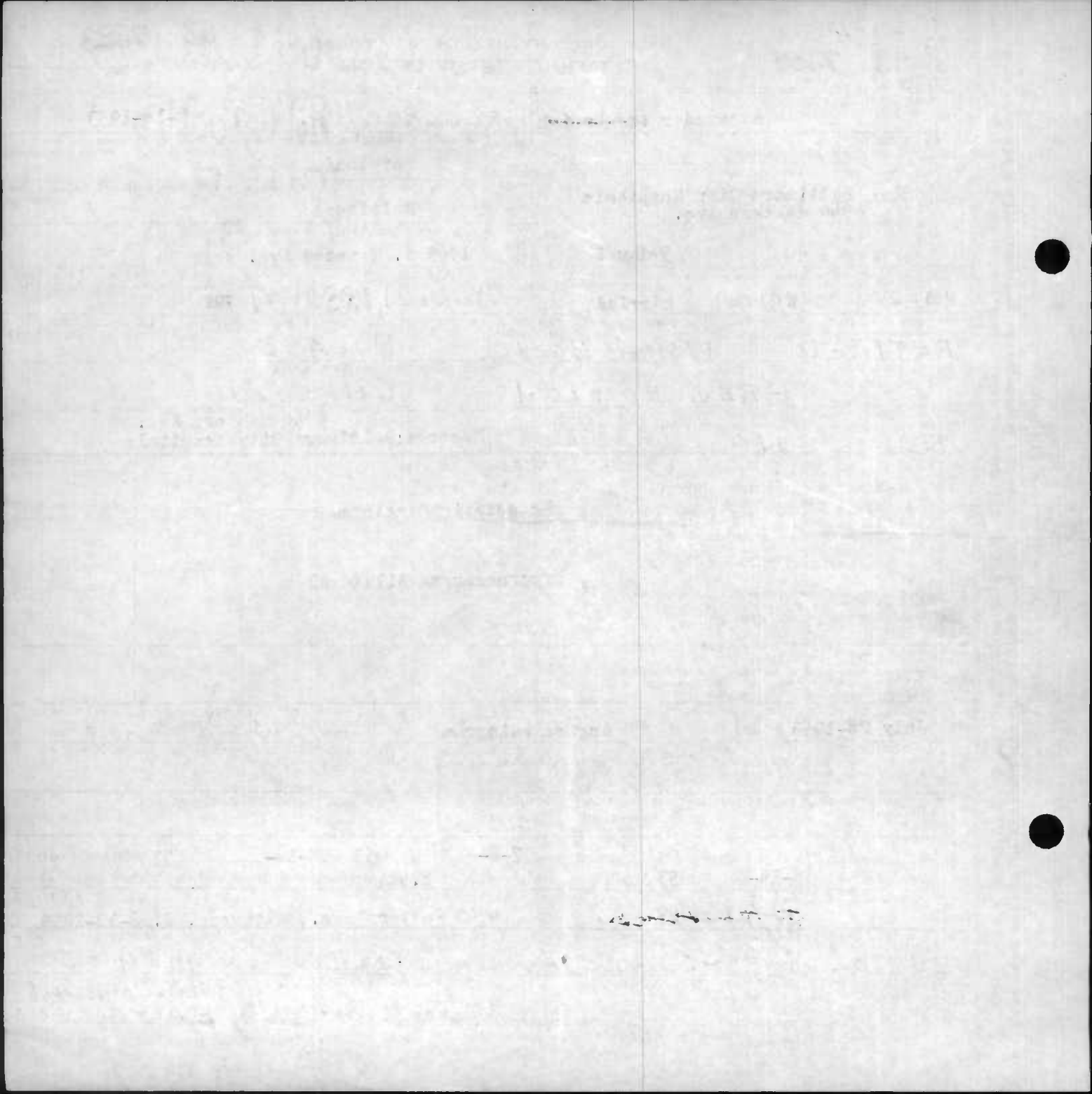
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

Charles J. Zeller 901 S. CONKLING ST. BALTO., MD.

VS 150

690-35





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A-450  
53 7389

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>FRED ALLEN</b>		2. DATE OF DEATH <b>8/17/53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Anne Arundel</b>			
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>University Hoop.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Annapolis Junction 5200</b>			
C. Length of stay in Baltimore <b>2</b> <sup>Yrs.</sup> <sub>Days</sub>		D. STREET ADDRESS (If rural, give location) <b>Annapolis Junction A. A. County</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>		8. DATE OF BIRTH <b>Unknown</b>	9. AGE (In years last birthday) <b>80-?</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Hand</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Nathan Allen</b>		14. MOTHER'S MAIDEN NAME <b>Adaline Brogan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT ADDRESS <b>Fred Allen Jessups Md</b>	
18. <b>204.2</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute monocytic leukemia</b> (A) _____ DUE TO ANTECEDENT CAUSES (B) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Malnutrition</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>8/14</b> 19 <b>53</b> , to <b>8/17</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>8/15</b> , 19 <b>53</b> , and that death occurred at <b>4:58 P</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>J. H. Weiner</b>		23B. ADDRESS <b>University Hoop.</b>		23C. DATE SIGNED <b>8/17/53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug 19, 1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>George Town Cemetery Near Jessups Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 18 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>		25. FUNERAL DIRECTOR <b>Ribgley Selby 401 Wash ave Laurel Md</b>	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-536  
53 7390

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7390  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Mary Henderson

2. DATE  
OF DEATH

Aug. 17, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md.

B. COUNTY \_\_\_\_\_

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

1221 Whatcoat St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto.

76-02

c. Length of stay in Baltimore

?

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

1221 Whatcoat St.

5. SEX

Female

6. COLOR OR RACE

C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

9/8/15

9. AGE (In years last birthday)

37

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

H. 1221

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Edward Crane

14. MOTHER'S MAIDEN NAME

Betsy Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Alexander Henderson

ADDRESS

1221 Whatcoat St.

18.

492X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) VIRUS PNEUMONIA

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

5 DAYS

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from AUG 13, 1953, to AUG 17, 1953, that I last saw the deceased alive on AUG 16, 1953, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

B. Williams Frey

23B. ADDRESS

1928 Penna Ave

23C. DATE SIGNED

8/18/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/21/53

24C. NAME OF CEMETERY OR CREMATORY

Mt Auburn

24D. LOCATION (City, town, or county)

Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

1953

25. FUNERAL DIRECTOR

Geo. G. Kelson 1303 Presstman St.

ADDRESS

Geo. G. Kelson

0957 20

0957 20

1. The first part of the report deals with the general situation of the country. It is a very interesting and informative study of the country's development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a valuable contribution to the study of the country's development.

2. The second part of the report deals with the economic situation of the country. It is a very interesting and informative study of the country's economic development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a valuable contribution to the study of the country's economic development.

3. The third part of the report deals with the social situation of the country. It is a very interesting and informative study of the country's social development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a valuable contribution to the study of the country's social development.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

53 7391  
Registered No. \_\_\_\_\_

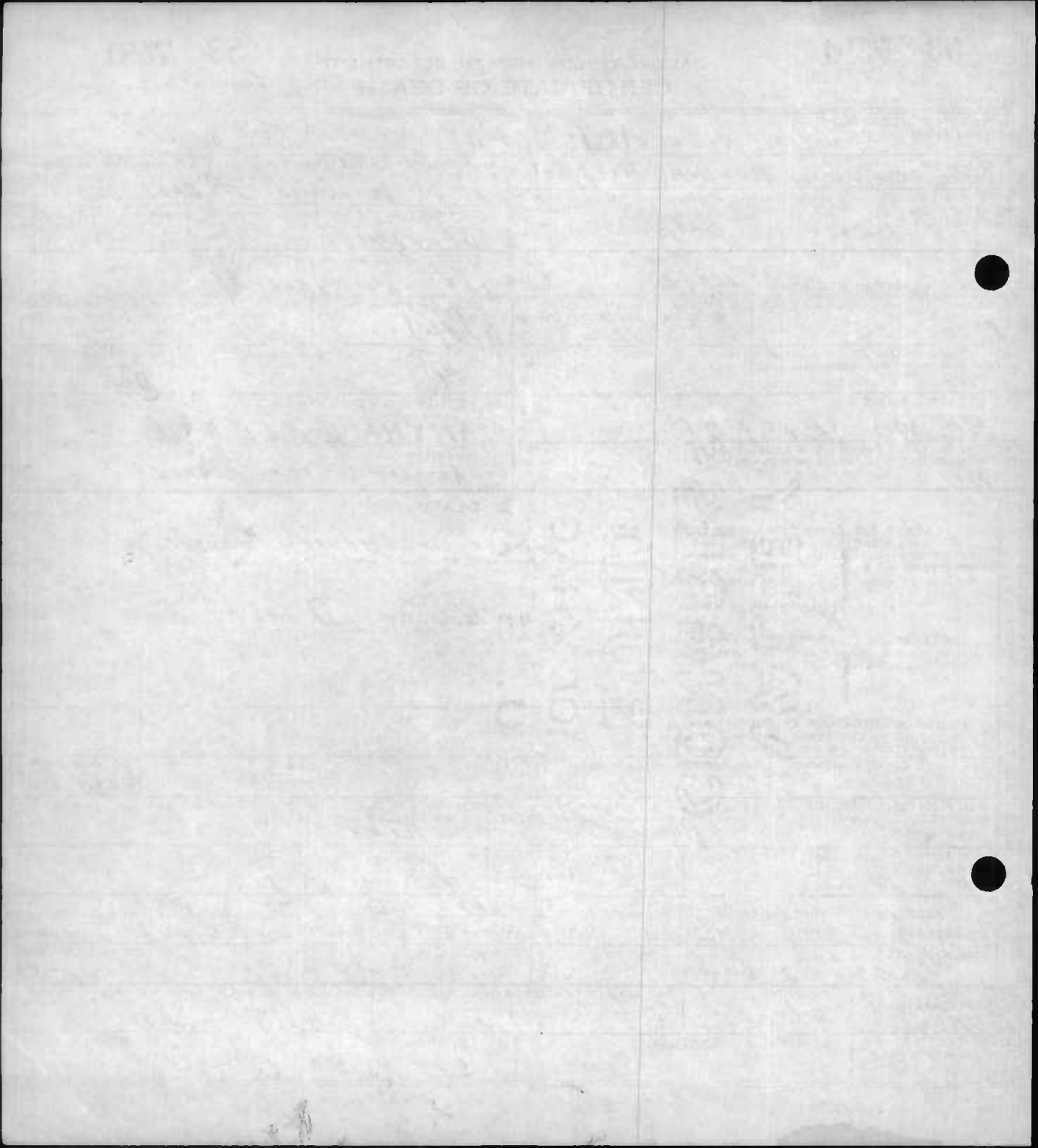
BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Estella Wallace (BISHOP)</i>		2. DATE OF DEATH <i>8-17-53</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Provident Hospital</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Provident Hospital</i>			
C. Length of stay in Baltimore <i>Life</i>		Yrs. Mos. Days	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>M.C.</i>		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <i>REMO BISHOP</i>		14. MOTHER'S MAIDEN NAME <i>MARTHA WALLACE</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. —	
17. INFORMANT <i>Accident Room Record-</i>		ADDRESS	

<p>18. <i>331X</i></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p align="center">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p align="center">CAUSE OF DEATH</p> <p>(A) <i>Massive intracranial Hemorrhage</i></p> <p>DUE TO</p> <p>(B) <i>Hypertensive Disease</i></p> <p>DUE TO</p> <p>(C) _____</p>	<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><i>Undet.</i></p>

19A. DATE OF OPERATION <i>2</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <i>F</i>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>Home</i>	
21D. TIME (Month) (Day) (Year) (Hour) INJURY <i>8-17-53</i>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>Fell off step</i>	
22. I hereby certify that I attended the deceased from <i>8-17</i> , 19 <i>53</i> , to <i>8-17</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>8-17</i> , 19 <i>53</i> , and that death occurred at <i>2:49</i> p. m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Joseph O. De la Cruz</i>		23B. ADDRESS <i>Provident Hospital</i>		23C. DATE SIGNED <i>8-17-53</i>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>8/20/53</i>		24C. NAME OF CEMETERY OR CREMATORY <i>ST. PETERS</i>		24D. LOCATION (City, town, or county) (State) <i>BALTO MD</i>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>Joseph O. De la Cruz</i>		25. FUNERAL DIRECTOR <i>Geo B Nelson</i>		ADDRESS	





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		53 7892 Registered No.	
1. NAME OF DECEASED (Type or Print) <b>WYMAN C. SMITH</b>			2. DATE OF DEATH <b>August 16, 1953</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>1306 N. Carey Street</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>W</b>	8. DATE OF BIRTH <b>12/2/99</b>		9. AGE (In years last birthday) <b>54</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
13. FATHER'S NAME <b>Chas. Smith</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>yes</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Ada Pitts</b>			ADDRESS <b>1108 Mosher St. Balto 17</b>		
18. <b>E 983x</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Generalized toxemia</b> DUE TO <b>lung abscess--right</b> DUE TO <b>occipital bilateral subdural hematoma</b> DUE TO					INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>shop</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>1209 Laurens Street</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>8-2-53 4:15 P.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>down</b> <b>presumably hit his head when shoved</b>	
22. I certify that I took charge of the remains described above, held an <b>autopsy</b> thercon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>R. Fisher</b>		23B. CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER MEDICAL INVESTIGATOR		23C. DATE SIGNED <b>8-17-53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/20/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Balto. National</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25. FUNERAL DIRECTOR <b>Geo. G. Kelson 1303 Presstman St.</b>			
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		ADDRESS	
VS 151		N-854.0		78099-Geo. G. Kelson	

503X 28

503X 28



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Baltimore City Health Department				53 7393		Registered No.	
BIRTH NO.				53 7393			
1. NAME OF DECEASED (Type or Print)				2. DATE OF DEATH			
SARAH RUANE				AUG. 17, 1953			
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
B. FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE			
St. Joseph's Hospital				New Jersey			
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)			
				East Teensburg			
c. Length of stay in Baltimore				51 Neptune.			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
female		white		widowed		March 9, 1879	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)	
housewife		at home		74		Ireland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
UNKNOWN				UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT	
						Mr. John Ruane, 80 Highland Ave.	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
(A) Arteriosclerotic cardiovascular disease				INTERVAL BETWEEN ONSET AND DEATH			
DUE TO							
ANTECEDENT CAUSES							
(B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				DUE TO			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION				19B. MAJOR FINDINGS OF OPERATION			
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
				WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I took charge of the remains described above, held an <u>Inspection &amp; inquiry</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> , <u>accident</u> <input type="checkbox"/> , <u>suicide</u> <input type="checkbox"/> , <u>homicide</u> <input type="checkbox"/> , <u>undetermined</u> <input type="checkbox"/> .							
23A. SIGNATURE				23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED	
Joseph A. Jachims				M.D.		8/18/53	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Aug 21 53		Holy Sepulchre		East Orange, N.J.	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR		ADDRESS	
Aug 18 1953		[Signature]		William Cook, Inc.		1217 51 Pavy	

Inspection & Industry

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **53 7394**

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LOUIS C. DAUDELIN</b>		2. DATE OF DEATH <b>8/17/53</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTO., INC.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 11-02</b>	
c. Length of stay in Baltimore <b>42</b> Yrs. Mos. Days		d. STREET ADDRESS (If rural, give location) <b>1010 ST. PAUL ST.</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>	8. DATE OF BIRTH <b>FEB 9, 1890</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHYSICIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>63</b>
11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LOUIS DAUDELIN</b>		14. MOTHER'S MAIDEN NAME <b>ELLEN STONE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>ROSE E DAUDELIN</b>		ADDRESS <b>1010 ST. PAUL ST</b>	

18. <b>332X</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRAL THROMBOSIS</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>80 hrs</b>
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>ARTERIO SCLEROSIS</b> DUE TO		
(C)		

**II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.**

19a. DATE OF OPERATION <b>8/17/53</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **8/14**, 19**53**, to **8/17**, 19**53**, that I last saw the deceased alive on **8/17**, 19**53**, and that death occurred at **829** m., from the causes and on the date stated above.

23a. SIGNATURE <b>Stanley B. Gould</b>		23b. ADDRESS <b>Sinai Hospital</b>		23c. DATE SIGNED <b>8/17/53</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>8/20/53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cmn</b>	24d. LOCATION (City, town, or county) <b>Balti City</b>	(State)
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <b>Charles H. Ganssen</b>	25. FUNERAL DIRECTOR <b>1782 W. Mt. Royal Ave</b>		

**AUG 18 1953** **Huntington** **7 38 PM** **Mt. Royal Ave**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

J-525  
53 7395

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7395  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
JOHN T. JOHNSON		AUG. 16, 1953	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
603 S. GRUNDY ST.		MD.	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
		BALTIMORE 26-07	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location)	
		603 S. GRUNDY ST.	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
MALE	WHITE	MARRIED	MAR. 25, 1887
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years, last birthday)
RETIRED		BETHLEHEM STEEL	66
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
BALTIMORE, MD.		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
JOHN J. JOHNSON		LAURA V. LAWSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO NO		213-07-5969	ELIZABETH JOHNSON SAME
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			
(A) Uremia			
DUE TO			
Ante cedent causes			
(B) Arteriosclerosis			
DUE TO			
(C)			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
Pulmonary emphysema St. Hely's			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
0			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8/13, 1953, to 8/16, 1953, that I last saw the deceased alive on 8/15, 1953, and that death occurred at 3:30 P. m., from the causes and on the date stated above.			
23A. SIGNATURE		23B. ADDRESS	23C. DATE SIGNED
Charles J. Black		101 E. Biddle St.	8/18/53
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	8-19-53	MORELAND MEMORIAL	TAYLOR AVE. BALTO CO
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS	
AUG 18 1953	Huntington Williams	901 S. CONKLING ST. BALTO., MD.	

LN

Blazek

101 E. Biddle St

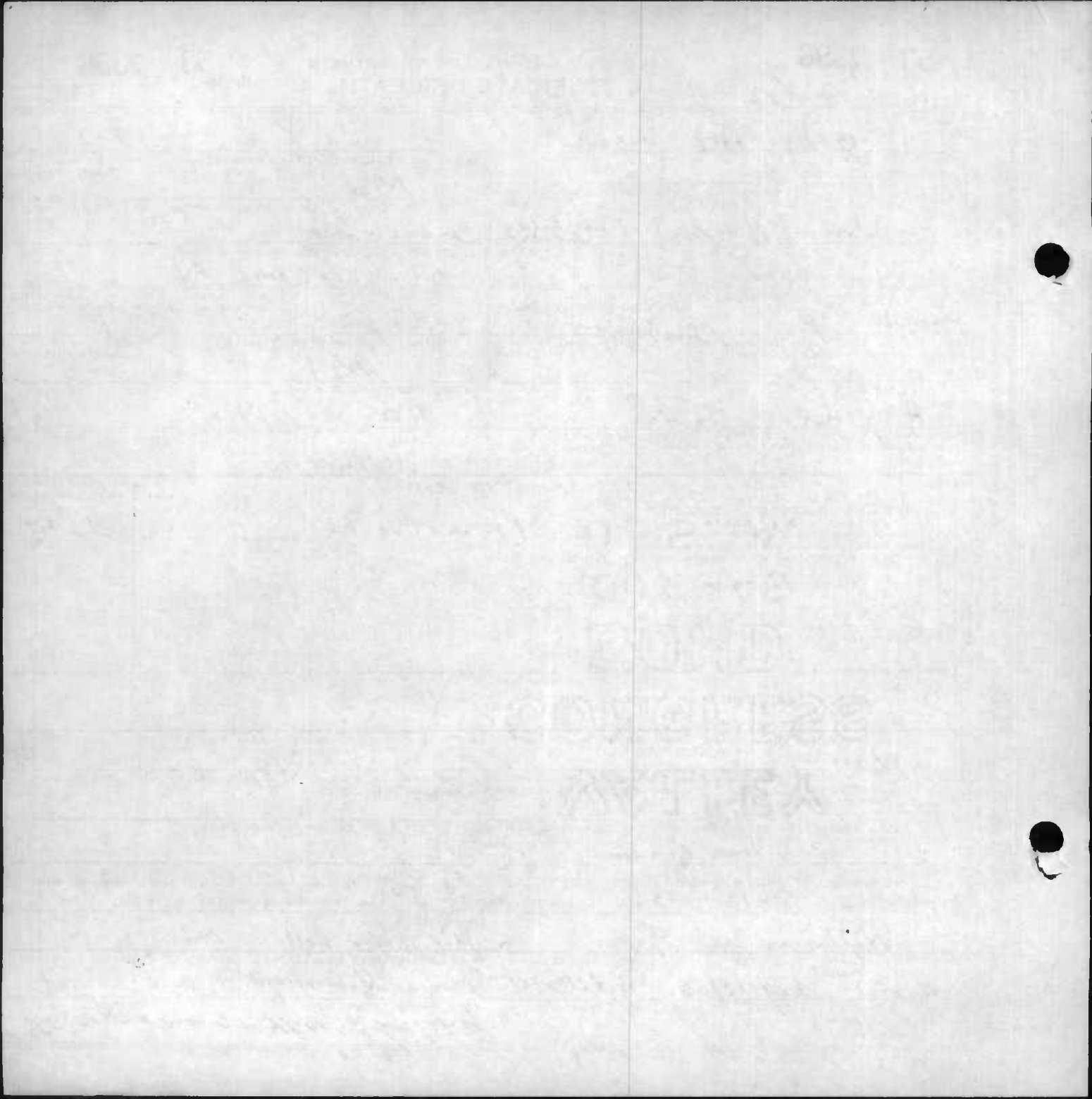
La. 7-3038.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7396  
Registered No.

BIRTH NO. <i>2.000</i> <i>53 7396</i> <i>For Res.</i>		2. DATE OF DEATH <i>8-18-53</i>	
1. NAME OF DECEASED (Type or Print) <i>Baby Girl Lowe</i>		3. PLACE OF DEATH: A. Baltimore City, Maryland	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Univ. Hospital Longwood</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Anne Arundel</i>	
C. Length of stay in Baltimore <i>38</i> Yrs. Mos. Days		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Edgewater</i>	
D. STREET ADDRESS (If rural, give location) <i>5119 Tokomo Rd. 5200</i>		5. SEX <i>Female</i>	
6. COLOR OR RACE <i>W</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Infant</i>	
8. DATE OF BIRTH <i>8-16-53</i>		9. AGE (In years last birthday) <i>1</i> If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>Reginald Lowe</i>		14. MOTHER'S MAIDEN NAME <i>Mary Carter</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Father</i>		ADDRESS	
18. <i>776x</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Prematurity</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>33 hrs.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19C. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>8-17-1953</i> to <i>8-18, 1953</i> that I last saw the deceased alive on <i>8-18, 1953</i> and that death occurred at <i>5:00 a. m.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>William A. Tyson</i> M. D.		23B. ADDRESS <i>Univ. Hosp. Balt. 1 Md.</i>	
23C. DATE SIGNED <i>8-18-53</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Aug 19/53</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>St. Vincent Memorial</i>		24D. LOCATION (City, town, or county) (State) <i>Annapolis, a. a. Ind</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 18 1953</i>		25. FUNERAL DIRECTOR <i>B. L. Hopping &amp; Son Annapolis, Md.</i>	
REGISTRAR'S SIGNATURE <i>Huntington Williams</i>		ADDRESS	



W-325  
53 7397  
BIRTH NO. 53-05194BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7397  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Stephen Watson</i>		2. DATE OF DEATH <i>Aug. 6, 1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Maryland</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>14-01</i>	
C. Length of stay in Baltimore <i>life</i>		D. STREET ADDRESS (If rural, give location) <i>125 W. Moser St. Musher St</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>8/10/53</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
13. FATHER'S NAME <i>Clarence Watson</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Kinly</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Catherine Kinly</i>		ADDRESS <i>125 W. Moser St.</i>	
18. 754.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Dextro. Cardia and</i> DUE TO (B) <i>Possible Single Venicle</i> DUE TO (C)  INTERVAL BETWEEN ONSET AND DEATH <i>Spont.</i> <i>Smooth</i>	
19A. DATE OF OPERATION <i>7</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Aug. 6 8:30 A.M.</i> , 19 <i>53</i> , to <i>Aug. 6 8:45 A.M.</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>Aug. 6</i> , 19 <i>53</i> , and that death occurred at <i>8:45 A.M.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>Deed T. Key</i>		23B. ADDRESS <i>Maryland General Hospital</i>	
23C. DATE SIGNED <i>8/6/53</i>		23D. M. D.	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE	
24C. NAME OF CEMETERY OR CREMATORY <i>UNIVERSITY MEDICAL SCHOOL</i>		24D. LOCATION (City, town, or county) (State) <i>Aug. 14, 1953</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 18 1953</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>	
25. FUNERAL DIRECTOR <i>Huntington Williams</i>		ADDRESS	

LO-6-2500



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **53 7398**

BIRTH NO. **53 7398**

1. NAME OF DECEASED (Type or Print) <b>Nicholas Aloysius Brennan</b>	2. DATE OF DEATH <b>Aug. 17/53</b>
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3. PLACE OF DEATH: A. Baltimore City, Maryland	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Agnes' Hosp.</b> <b>Wilkins &amp; Caton Aves.</b>	C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Catonsville</b>
D. STREET ADDRESS (If rural, give location) <b>6300 Mount Ridge Rd.</b>	

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 11, 1894</b>	9. AGE (in years last birthday) <b>59</b>	10. Under 1 Year Months: Days	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Loan Examiner</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Veterans Administration</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
12. CITIZEN OF WHAT COUNTRY?						

13. FATHER'S NAME <b>Nicholas T. Brennan</b>	14. MOTHER'S MAIDEN NAME <b>Margaret Brennan</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>	16. SOCIAL SECURITY NO. <b>W.W.1</b>
17. INFORMANT ADDRESS <b>Mrs. Viola Brennan, 6300 Mt. Ridge Rd.</b>	

18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CORONARY OCCLUSION (SPASM)</b> <b>SUBACUTE GASTROENTERITIS</b> <b>ARTERIAL HYPERTENSION.</b>	INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>3 Mo.</b> <b>?</b>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **June 11, 1953** to **Aug. 17, 1953** that I last saw the deceased alive on **Aug. 15, 1953** and that death occurred at **6:30 P.m.**, from the causes and on the date stated above.

23A. SIGNATURE <b>S. Lloyd Johnson</b>	23B. ADDRESS <b>Catonsville Md.</b>	23C. DATE SIGNED <b>8/18/53</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Aug. 20/53</b>	24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		

DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 19 1953</b>	REGISTRAR'S SIGNATURE <b>Harry H. Kutzke</b>	25. FUNERAL DIRECTOR ADDRESS <b>4101 Edmondson Ave.</b>
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MEDICAL CERTIFICATION

1957

STATE OF NEW YORK

1957

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

53 7399

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7399

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Anna Margaret Corwell

2. DATE  
OF  
DEATH

Aug. 17/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

841 Stamford Rd.

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

841 Stamford Rd

C. Length of stay in Baltimore

35 yrs

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

July 15/81

9. AGE (in years last birthday)

72

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Bookkeeper

10B. KIND OF BUSINESS OR

American Stores

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Charles M. Corwell

14. MOTHER'S MAIDEN NAME

Anna J.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

(218 05 0733)

17. INFORMANT

ADDRESS

A)-----Mrs. Ruth Gaskins, 841 Stamford

18. 154X

CAUSE OF DEATH

RD INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) Carcinoma of rectum  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) metastasis - stomach and liver 6 mo.  
DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22. I hereby certify that I attended the deceased from June 1, 1953, to Aug 17, 1953, that I last saw the deceased alive on Aug 14, 1953, and that death occurred at 10 a. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

Aug. 19/53

Meadowridge Mem. Pk.

Dorsey, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

1953

Harry F. Williams, M.D.

Harry F. Williams

4101 Edmondson Ave.

Walter S. Niblett

2220 Max. Shl

S-512  
4 53 7400BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7400  
Registered No.

BIRTH NO.	
1. NAME OF DECEASED (Type or Print) <b>Barbara H. Snoops</b>	
2. DATE OF DEATH <b>Aug. 15/53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>20-05</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <b>428 S. Smallwood St</b>	
C. Length of stay in Baltimore <b>72 yrs.</b> Yrs. <b>72</b> Mos. <b>0</b> Days <b>0</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>July 6, 1872</b>
9. AGE (in years last birthday) <b>81</b>	10. Under 1 Year Months <b>0</b> Days <b>0</b>
11. Under 24 Hours Hours <b>0</b> Min. <b>0</b>	10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>
10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Germany</b>
12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME <b>Henry Rausch</b>
14. MOTHER'S MAIDEN NAME <b>Margaret Miller</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>
16. SOCIAL SECURITY NO.	17. INFORMANT <b>Leroy F. Snoops, 124 Allendale St</b>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>HEPATIC CIRRHOSIS</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>ASCITES, TENSE</b> DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>NONE SIGNIF.</b>	
19A. DATE OF OPERATION <b>0</b>	
19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	21D. TIME (Month) (Day) (Year) (Hour) INJURY
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>NONE</b>
22. I hereby certify that I attended the deceased from <b>MAY 1952</b> , to <b>AUG. 1953</b> , that I last saw the deceased alive on <b>AUG. 8, 1953</b> , and that death occurred at <b>1030 P.M.</b> , from the causes and on the date stated above.	
23A. SIGNATURE <b>Daniel E. Fisher</b>	23B. ADDRESS <b>1707 Edmondson Ave. Catonsville, Md.</b>
23C. DATE SIGNED <b>18 Aug 53</b>	24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>
24B. DATE <b>Aug. 19/53</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>	25. FUNERAL DIRECTOR <b>Harry H. Smith</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 19 1953</b>	REGISTRAR'S SIGNATURE <b>Harry H. Smith</b>
ADDRESS <b>4101 Edmondson Ave.</b>	

MEDICAL CERTIFICATION

0085

DEPARTMENT

UNITED STATES

NOV 1950

1





A-130  
53 7401

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7401

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CLAUDE A. ABBOTT

2. DATE  
OF  
DEATH

8/18/53

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
MARYLAND

B. COUNTY

BALTIMORE

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

OWINGS MILLS

d. STREET ADDRESS (If rural, give location)

6300

Length of stay in Baltimore

60

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

2-17-1893

9. AGE (In years last birthday)

60

10. Under 1 Year

Months

Days

11. Under 24 Hours

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Railroad mail clerk

10b. KIND OF BUSINESS OR INDUSTRY

Railroad

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

William A. Abbott

14. MOTHER'S MAIDEN NAME

Margaret Hammond

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

Yes

World War I

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

Blanche M. Abbott Owings Mills

18. 422.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral vascular accident

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Interosseal cardiac vascular disease

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

8 hrs

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) INJURY

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/18/53, 19, to 8/18/53, 19, that I last saw the deceased alive on 8/18/53, 19, and that death occurred at 5:12 p.m., from the causes and on the date stated above.

23a. SIGNATURE

Henry Z. Knock, Jr.

M. D.

23b. ADDRESS

Union Memorial Hospital

23c. DATE SIGNED

8/18/53

24a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24b. DATE

Aug 21-53

24c. NAME OF CEMETERY OR CREMATORY

St. Thomas

24d. LOCATION (City, town, or county)

Owings Mills Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

1953000

25. FUNERAL DIRECTOR

ADDRESS

F. Elmer, Mrs Rutenstrum Md

CERTIFICATE OF DEATH

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>	
<p>3. Age: _____</p>		<p>4. Date of birth: _____</p>	
<p>5. Place of birth: _____</p>		<p>6. Date of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Manner of death: _____</p>	
<p>9. Signature of physician: _____</p>		<p>10. Signature of registrar: _____</p>	
<p>11. Date of registration: _____</p>		<p>12. Place of registration: _____</p>	
<p>13. Name of informant: _____</p>		<p>14. Address of informant: _____</p>	
<p>15. Signature of informant: _____</p>		<p>16. Date of completion: _____</p>	

K-500

53 7402

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7402

1. NAME OF DECEASED (Type or Print) <b>MARGARET VIRGINIA KENNY</b>		2. DATE OF DEATH <b>8/16/53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <b>Mercy Hospital, Inc.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 27-17</b>	
D. STREET ADDRESS (If rural, give location) <b>5309 ETHELBEAT AVE.</b>		5. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, <del>WIDOWED</del> , DIVORCED (Specify)	8. DATE OF BIRTH <b>6/23/1874</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>79</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN LATCHAM</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH GIBBON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Agnes Miles</b>		ADDRESS <b>5309 Ethelbeat Ave.</b>	
18. <b>561.1</b> CAUSE OF DEATH: DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) STRANGULATED FEMORAL HERNIA</b> DUE TO <b>(B) ...</b> DUE TO <b>(C) ...</b> INTERVAL BETWEEN ONSET AND DEATH <b>Over 2 weeks</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DIS.</b> <b>Over 10 yrs</b>			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>8/12/53</b> , 19 <b>53</b> , to <b>8/16</b> , 19 <b>53</b> that I last saw the deceased alive on <b>8/16</b> , 19 <b>53</b> and that death occurred at <b>6:55 PM</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>John W. Hume Jr.</b>		23B. ADDRESS <b>Mary Hs.</b>	
23C. DATE SIGNED <b>8/16/53</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
24E. DATE RECEIVED BY LOCAL REGISTRAR		24F. REGISTRAR'S SIGNATURE	
24G. FUNERAL DIRECTOR'S ADDRESS		24H. SIGNATURE	

MEDICAL CERTIFICATION



K-235  
53 7403BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7403

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Emma Gardner Kastendike</i>		2. DATE OF DEATH <i>8-18-53</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 12-02</i>	
D. Length of stay in Baltimore <i>40 years</i>		E. STREET ADDRESS (If rural, give location) <i>Home wood Apts.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>12 Oct. 1884</i>
9. AGE (In years last birthday) <i>68</i>		10. UNDER 1 Year Months: Days	11. UNDER 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>*Unknown*</i>		14. MOTHER'S MAIDEN NAME <i>Emily Duvall</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>George H. Kastendike, III</i>		ADDRESS <i>333 Tunbridge Rd.</i>	

18. <i>443X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH (A) <i>Cerebral vascular accident recurrent.</i> (B) <i>Hypertensive arteriosclerotic cardiovascular disease.</i> (C)  INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <i>✓</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *8-17*, 19*53*, to *8-18*, 19*53* that I last saw the deceased alive on *8-18*, 19*53*, and that death occurred at *4:25 am.*, from the causes and on the date stated above.

23A. SIGNATURE, *Marjorie H. Hendry* M. O. *Union Memorial Hospital* 23B. ADDRESS *8-18-53* 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) *burial* 24B. DATE *8-20-53* 24C. NAME OF CEMETERY OR CREMATORY *Druid Ridge* 24D. LOCATION (City, town, or county) (State) *Pikesville, Md.*

DATE RECEIVED BY LOCAL REGISTRAR *AUG 19 1953* REGISTRAR'S SIGNATURE *Huntington* 25. FUNERAL DIRECTOR *John A. Mitchell & Son, Inc.* ADDRESS *1900 Eutaw Place*

1003

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

NO. 1003  
JAN 2 1903

PLANT INDUSTRY

PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.



B-650

53 7404

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7404  
Registered No.

BIRTH NO. 53-17515

1. NAME OF DECEASED  
(Type or Print)

George Brown Jr.

2. DATE  
OF  
DEATH

8-14-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

Univ. Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore 17-02

38  
Length of stay in BaltimoreYrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

1106 Brewer St.

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Infant

8. DATE OF BIRTH

7-31-53

9. AGE (In years  
last birthday)If Under 1 Year  
Months Days Hours Min.

14

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY

13. FATHER'S NAME

George Brown Sr.

14. MOTHER'S MAIDEN NAME

Bertha Heard ✓

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Father

ADDRESS

1106 Brewer St.

18. 764.0

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Diarrhea - dehydration - acidosis

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Same as above

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 14th, 1953, to August 14th, 1953, that I last saw the  
deceased alive on Aug. 14th, 1953, and that death occurred at 4:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE

L. V. Lema, M.D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

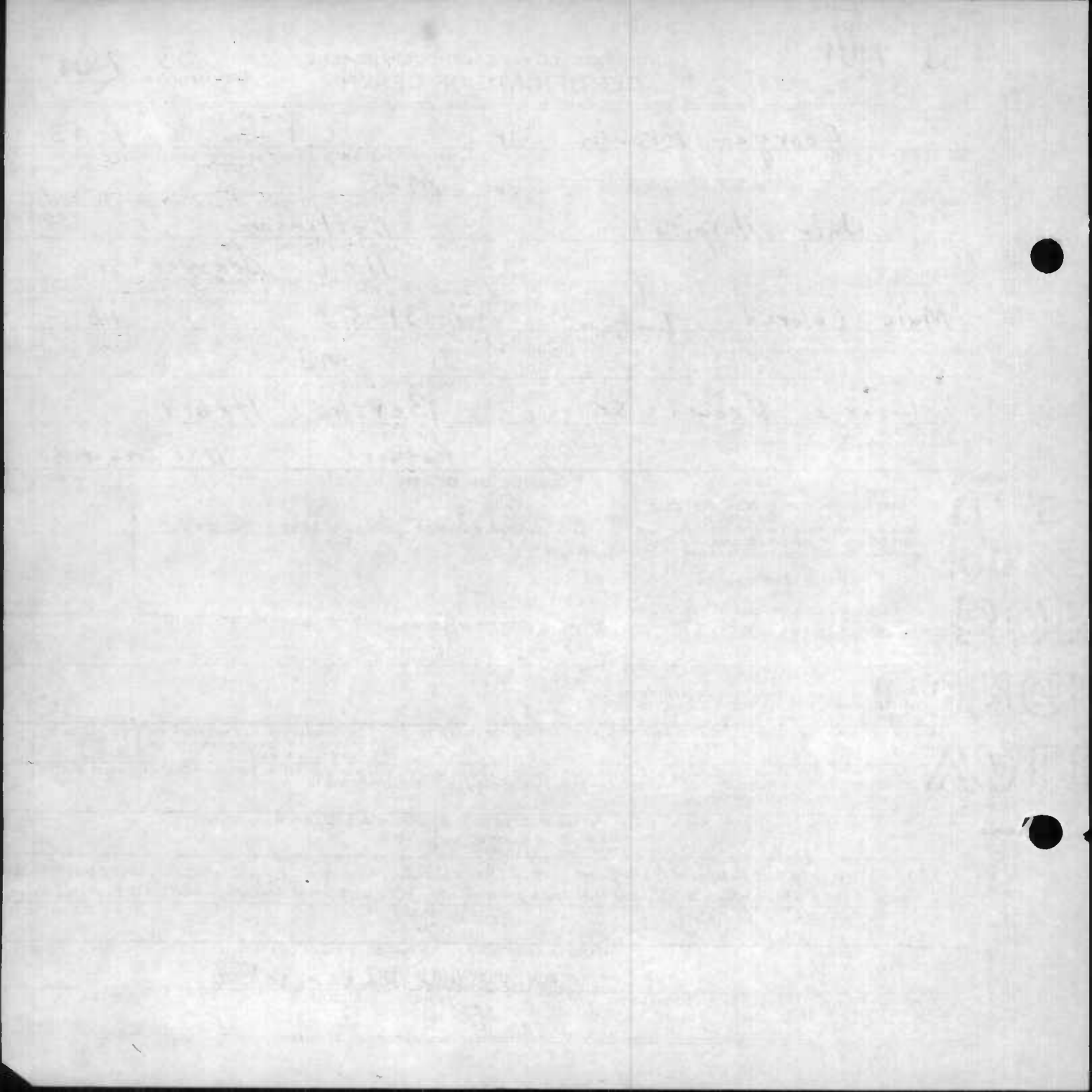
JOHN HOPKINS MEDICAL SCHOOL Aug 18, 1953

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S

ADDRESS



G-650

53 7405

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7405

Registered No.

BIRTH NO. 53-18706

1. NAME OF DECEASED (Type or Print) <u>Baby Girl Green "A"</u>			2. DATE OF DEATH <u>8-11-53</u>		
3. PLACE OF DEATH: A. <u>Baltimore City, Maryland</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> <del>1504-B</del> B. COUNTY <u>24-04</u>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <u>University Hospital</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>		
D. STREET ADDRESS (If rural, give location) <u>1504 Byrd St</u>			E. LENGTH OF STAY IN BALTIMORE <u>4</u> Yrs. Mos. Days		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, <del>MARRIED</del> , <del>WIDOWED</del> , <del>DIVORCED</del> (Specify)	8. DATE OF BIRTH <u>8-11-53</u>		9. AGE (In years, last birthday) <u>4</u> Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>premature</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Univ Hosp.</u>	
13. FATHER'S NAME <u>JOHN GREEN</u>			12. CITIZEN OF WHAT COUNTRY?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Mother</u>			ADDRESS		

18. <u>776X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <u>Prematurity</u>		INTERVAL BETWEEN ONSET AND DEATH	
(A) DUE TO					
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			

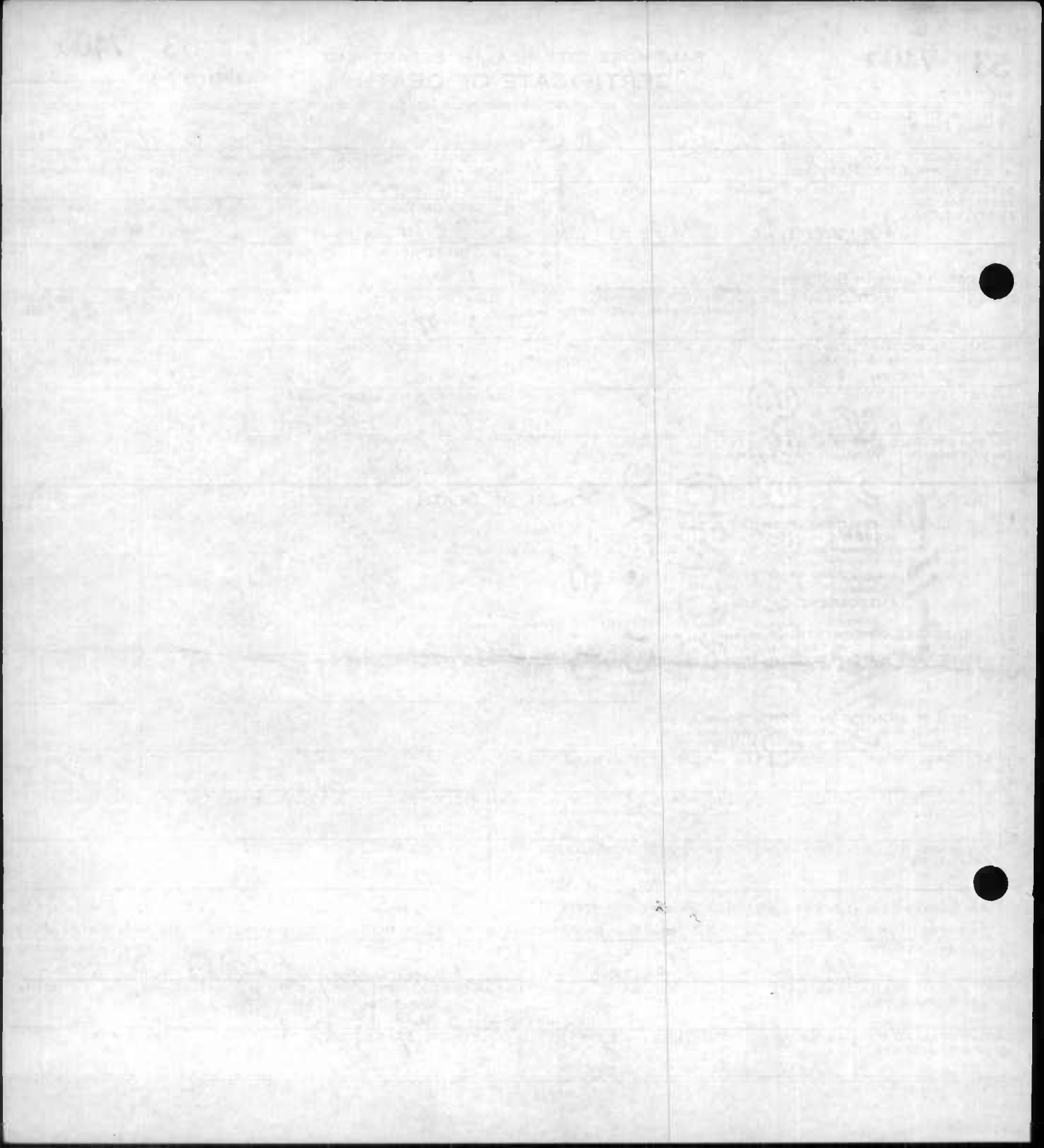
19A. DATE OF OPERATION <u>7</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 8-7-53, 1953, to 8-11-, 1953, that I last saw the deceased alive on 8-11, 1953, and that death occurred at 12 30 m., from the causes and on the date stated above.

23A. SIGNATURE <u>W. L. Heimer</u> M. D.		23B. ADDRESS <u>University Hospital</u>		23C. DATE SIGNED <u>8-11-53</u>	
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24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
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DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <u>Huntington</u>	25. FUNERAL DIRECTOR <u>Huntington Williams</u>	ADDRESS
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M-624  
53 7406  
BIRTH NO. 53-18708BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7406

1. NAME OF DECEASED (Type or Print) <b>JOYCE MARSHALL</b>			2. DATE OF DEATH <b>Aug. 11, 1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>18-01</b>		
D. LENGTH OF STAY IN BALTIMORE <b>5 hours</b>			D. STREET ADDRESS (If rural, give location) <b>811 W. 5th St. Fayette St.</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>Aug 11, 1953</b>	9. AGE (In years last birthday) <b>5 hours</b>	10. Under 1 Year Months Days <b>5 0</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>infant</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland.</b>	
13. FATHER'S NAME <b>Nathaniel Marshall</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Mother</b>			18. <b>811 W. 5th St. Balt.</b>		

18. <b>776X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <b>Prematurity</b> DUE TO (B) _____ DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH <b>5 hours.</b>
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19A. DATE OF OPERATION <b>7/15/53</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>1:15 a.m. 8/11, 1953</b> , to <b>6:15 a.m. 8/11, 1953</b> , that I last saw the deceased alive on <b>8/11, 1953</b> , and that death occurred at <b>6:15 a.m.</b> , from the causes and on the date stated above.		
23A. SIGNATURE <b>M. O. Merrill</b>	23B. ADDRESS <b>1718-A Glen Keith Blvd., Town 4</b>	23C. DATE SIGNED <b>8/11/53</b>

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <b>Huntington 5/11/53</b>	25. FUNERAL DIRECTOR <b>7 Huntington Williams, N.Y.</b>

JOHN HOPKINS MEDICAL SCHOOL 8/18/1953

100

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery		16. Signature of church	
17. Signature of family		18. Signature of friends		19. Signature of neighbors		20. Signature of community	
21. Signature of school		22. Signature of employer		23. Signature of business		24. Signature of government	
25. Signature of other		26. Signature of other		27. Signature of other		28. Signature of other	
29. Signature of other		30. Signature of other		31. Signature of other		32. Signature of other	
33. Signature of other		34. Signature of other		35. Signature of other		36. Signature of other	
37. Signature of other		38. Signature of other		39. Signature of other		40. Signature of other	
41. Signature of other		42. Signature of other		43. Signature of other		44. Signature of other	
45. Signature of other		46. Signature of other		47. Signature of other		48. Signature of other	
49. Signature of other		50. Signature of other		51. Signature of other		52. Signature of other	
53. Signature of other		54. Signature of other		55. Signature of other		56. Signature of other	
57. Signature of other		58. Signature of other		59. Signature of other		60. Signature of other	
61. Signature of other		62. Signature of other		63. Signature of other		64. Signature of other	
65. Signature of other		66. Signature of other		67. Signature of other		68. Signature of other	
69. Signature of other		70. Signature of other		71. Signature of other		72. Signature of other	
73. Signature of other		74. Signature of other		75. Signature of other		76. Signature of other	
77. Signature of other		78. Signature of other		79. Signature of other		80. Signature of other	
81. Signature of other		82. Signature of other		83. Signature of other		84. Signature of other	
85. Signature of other		86. Signature of other		87. Signature of other		88. Signature of other	
89. Signature of other		90. Signature of other		91. Signature of other		92. Signature of other	
93. Signature of other		94. Signature of other		95. Signature of other		96. Signature of other	
97. Signature of other		98. Signature of other		99. Signature of other		100. Signature of other	



J-525  
53 7407Dr. Heimer  
U.K.

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

53 7407  
Registered No.

BIRTH NO. 53-19208

1. NAME OF DECEASED  
(Type or Print)

Girl Johnson

2. DATE  
OF  
DEATH

8-14-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Univ Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Md

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 12-07D. STREET ADDRESS (If rural, give location)  
324 W 28 St

Length of stay in Baltimore

0

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

COLORED

7. (SINGLE) MARRIED.

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

8-14-53

9. AGE (In years last birthday)

11 Under 1 Year  
Months Days11 Under 24 Hours  
Hours Min.

2 2

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

U.S.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Charles Johnson

14. MOTHER'S MAIDEN NAME

Margaret Kelly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 776x

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) premature

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-14-1953 to 8-14-1953 that I last saw the deceased alive on 8-14-1953 and that death occurred at 10:50 A.M., from the causes and on the date stated above.

23A. SIGNATURE

W. L. Heimer

M. D.

23B. ADDRESS

University Hospital

23C. DATE SIGNED

8-14-53

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 19 1953

Huntington Williams, M.D.

7 408

Huntington Williams, M.D.



F-460  
53 7408

53 7408

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Franklin Brown Fuller</i>		2. DATE OF DEATH <i>8/17/53</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Provident Hosp</i> B. FULL NAME OF HOSPITAL OR INSTITUTION <i>PROVIDENT HOSPITAL</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY _____ C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 16-04</i> D. STREET ADDRESS (If rural, give location) <i>718 N. Fulton St</i>	
5. SEX <i>male</i>		6. COLOR OR RACE _____	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>		8. DATE OF BIRTH <i>10/24/07</i>	
9. AGE (In years last birthday) <i>45</i>		10. UNDER 1 Year: Months: Days _____	
11. UNDER 24 Hours: Hours: Min. _____		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <i>John Fuller</i>		14. MOTHER'S MAIDEN NAME <i>Mamie Harrington</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <i>216-09-5399</i>	
17. INFORMANT <i>William Fuller</i>		ADDRESS <i>718 N. Fulton St</i>	

18. *002X*

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

*Toxemia and Severe Emaciation*

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

*Far advanced Pulmonary tuberculosis*

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION *✓*

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

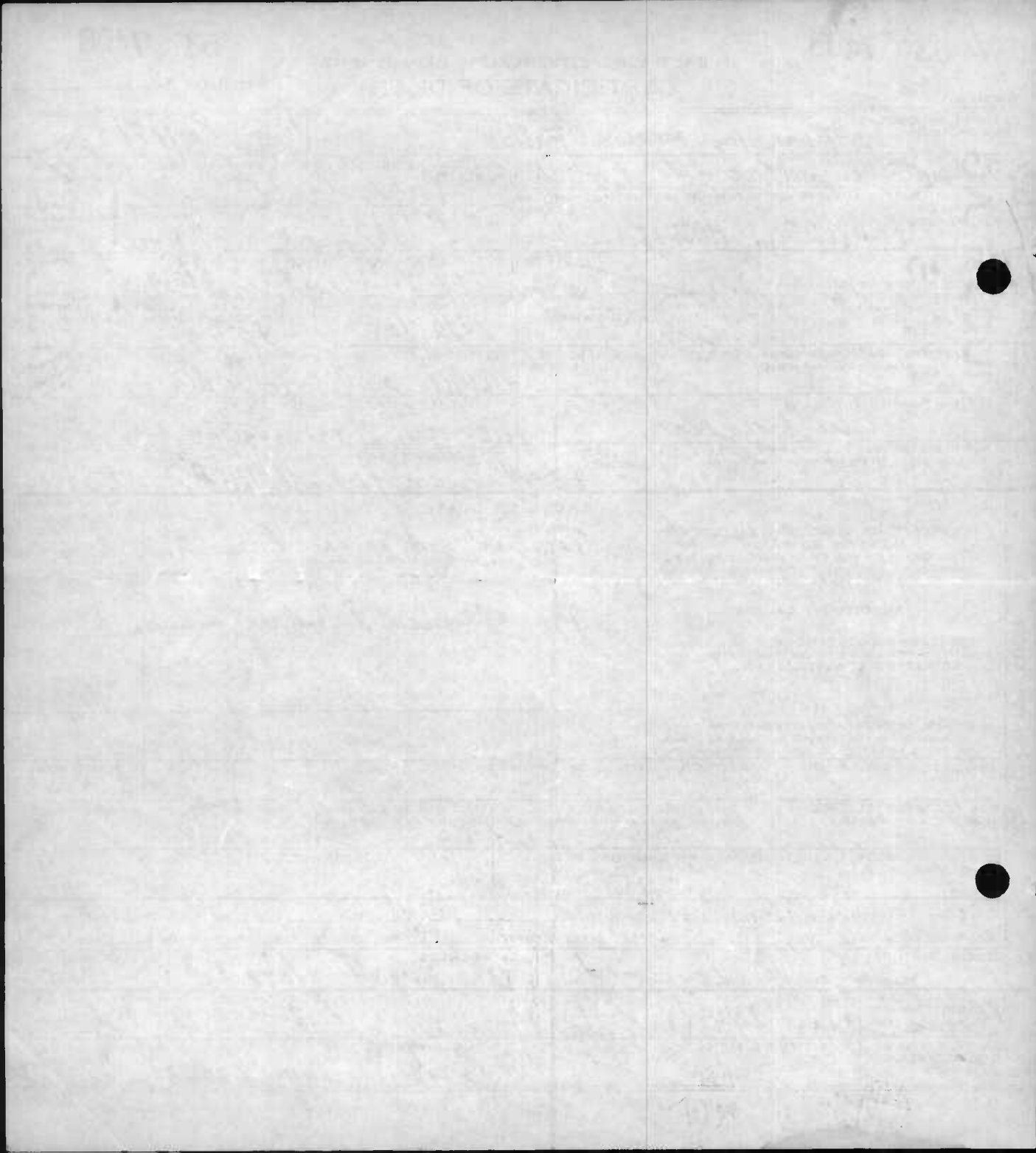
(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



5-632  
53 7409BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7409  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Gussie Sherotzky

2. DATE  
OF  
DEATH

8-18-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

Levondale

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore 5-01

D. STREET ADDRESS (If rural, give location)

1023 East Fayette St

C. Length of stay in Baltimore

41

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

Not known

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Rifka

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS  
Hal Sharrow 100 W Redwood

18. 443X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

Hypertensive and Arteriosclerotic  
Cardiovascular Disease  
General ArteriosclerosisINTERVAL BETWEEN  
ONSET AND DEATH

several years

many years

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-5, 1952, to 8-18, 1953, that I last saw the  
deceased alive on 8-18, 1953, and that death occurred at 430 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Dr. Boniomi

M. D.

23B. ADDRESS

Levondale

23C. DATE SIGNED

8-18-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

8-19-53

24C. NAME OF CEMETERY OR CREMATORY

Herring Run

24D. LOCATION (City, town, or county) (State)

Baltimore, Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Jas. K. Lewis 2100 East Ave

ADDRESS

Q101 13

Q101 13





G-355  
53 7410BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHX 53 7410  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Morris B. Doodman

2. DATE  
OF  
DEATH

8/18/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Mercy Hospital

C. Length of stay in Baltimore

43

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE District of Columbia B. COUNTY Wash DC.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Washington DC V-48

D. STREET ADDRESS (If rural, give location)

914 Sheridan Ave N.W.

5. SEX

M

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)Married ~~widowed~~

8. DATE OF BIRTH

1879

9. AGE (In years  
last birthday)

74

10 Under 1 Year  
Months Days11 Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Retail

10B. KIND OF BUSINESS OR  
INDUSTRY

Grocer

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Harry

14. MOTHER'S MAIDEN NAME

Harviah

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Dr Julius Goodman

18. 332X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Basilar Artery Thrombosis  
DUE TO

43 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) .....  
DUE TO  
(C) .....II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from 7/20, 1953, to 8/18/53, 1953, that I last saw the  
deceased alive on 8/12, 1953, and that death occurred at 12:00 m. from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

# CERTIFICATE OF DEATH

CASE NO. 100-240

DEATH OF JOHN J. ROBERTS  
 BORN 1880  
 DIED 1940  
 CAUSE OF DEATH  
 HEART DISEASE

ADVISORY BOARD

DEPARTMENT OF HEALTH  
 DIVISION OF VITAL RECORDS  
 BUREAU OF VITAL RECORDS

OTHER DEATHS  
 1940  
 1941  
 1942

IF THIS DEATH IS THE RESULT OF A DISEASE OR INJURY, THE CAUSE OF DEATH SHOULD BE SPECIFIED IN THE SPACE PROVIDED FOR THIS PURPOSE.

1940

W-425  
53 7411BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7411  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>William Norman Wilson</i>		2. DATE OF DEATH <i>8/17-53</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <i>3604 Spaulding Ave.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 27-18</i>	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>3604 Spaulding Ave.</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>July 29, 1873</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk (rtd)</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Wholesale Dry Goods</i>	9. AGE (in years last birthday) <i>80</i>
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Francis Wilson</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Beck</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>216-01-5669</i>	
17. INFORMANT <i>Mrs. Geo. Thompson</i>		ADDRESS <i>- 2135 Lorraine Ave.</i>	

18. *422.1*  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
*Old Hemiplegia of throat 10 yrs*  
*Cardio Vascular Disease?*

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)  
DUE TO  
(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) <i>8</i> INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *19*, to *19*, that I last saw the deceased alive on *11a*, 19, and that death occurred at *11a* m. from the causes and on the date stated above.

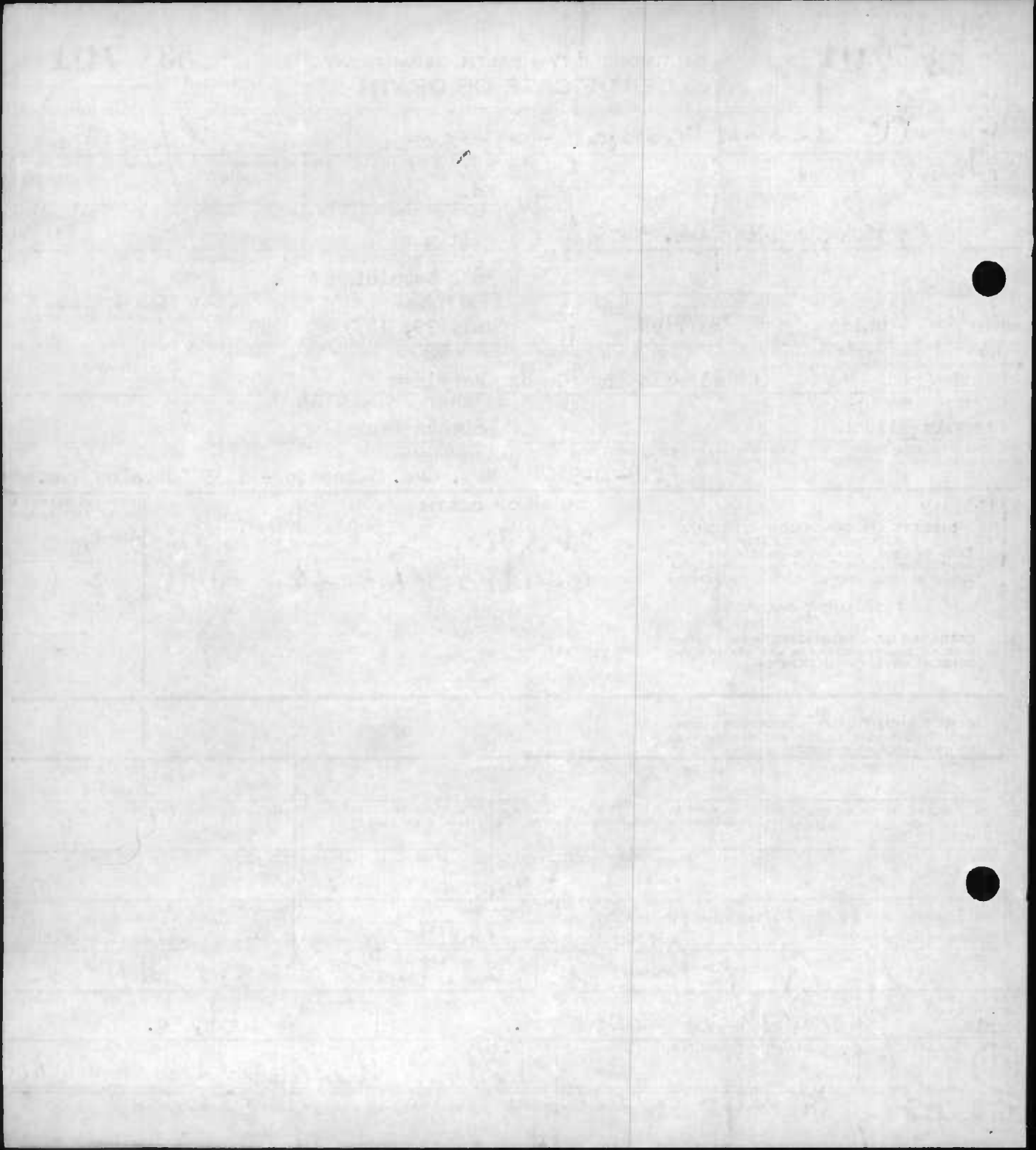
23A. SIGNATURE *H. R. Johnson* 23B. ADDRESS *103 Medarts Bg* 23C. DATE SIGNED *8/17-53*

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>8/20/53</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cem.</i>	24D. LOCATION (City, town, or county) (State) <i>Woodlawn, Md.</i>
--	-----------------------------	--	---

DATE RECEIVED BY LOCAL REGISTRAR *11-1-91453* REGISTRAR'S SIGNATURE *Huntington Williams, Jr.* 25. FUNERAL DIRECTOR *Thos. J. Dickner & Sons - Balt. Md.* ADDRESS

VS-10

created by Dr Geo Wells - now on vacation.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D-652  
53 7412

CERTIFICATE CORRECTED 9-14-53

53 7412

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

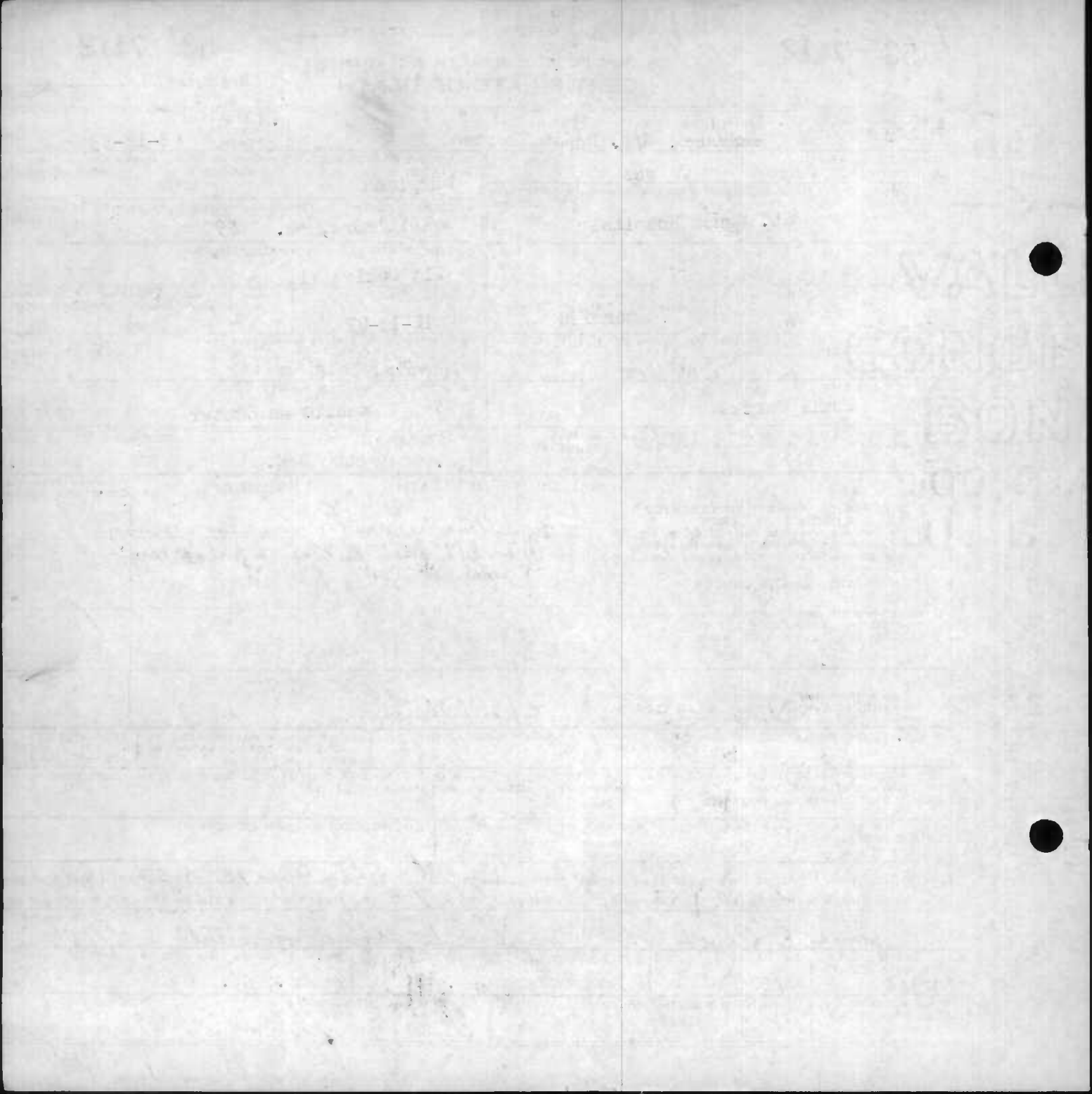
BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>DeRonge DeRonge, Mrs. Marie Therese</b>		2. DATE OF DEATH <b>8-18-53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>yes</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>St. Agnes Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore, Md. 29</b>	
c. Length of stay in Baltimore <b>40</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>215 Oaklee Village 5300</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>12-15-83</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Louvain, Belgium</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		12. CITIZEN OF WHAT COUNTRY? <b>Belgium</b>	
13. FATHER'S NAME <b>Louis Mercks</b>		14. MOTHER'S MAIDEN NAME <b>Rosalie De Coster</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Mrs. Charlotte DeR. Baker, 4508 Maple Ave.</b>		ADDRESS <b>4508 Maple Ave.</b>	

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Hypertensive cardiovascular disease</b> <b>to left heart failure &amp; pulmonary edema</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Cholelithiasis</b>		

19A. DATE OF OPERATION <b>Aug 18, 1953</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cholelithiasis</b>		19C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>St. Agnes Hospital</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.) <b>St. Agnes Hospital</b>		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>St. Agnes Hospital</b>		21D. HOW DID INJURY OCCUR? <b>St. Agnes Hospital</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>Aug 18, 1953</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>St. Agnes Hospital</b>		21G. HOW DID INJURY OCCUR? <b>St. Agnes Hospital</b>	

22. I hereby certify that I attended the deceased from <b>Aug 18, 1953</b> to <b>Aug 18, 1953</b> that I last saw the deceased alive on <b>Aug 18, 1953</b> , and that death occurred at <b>7 A</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>James E. Rowe Jr.</b>		23B. ADDRESS <b>St. Agnes Hospital</b>		23C. DATE SIGNED <b>8/18/53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/20/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>		25. FUNERAL DIRECTOR <b>Wm. J. Siskner &amp; Sons</b>		ADDRESS <b>Balto., Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>8/20/53</b>		REGISTRAR'S SIGNATURE <b>Wm. J. Siskner &amp; Sons</b>		25. FUNERAL DIRECTOR <b>Wm. J. Siskner &amp; Sons</b>	





M-624

MORSELL

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7413  
Registered No.

53 7413

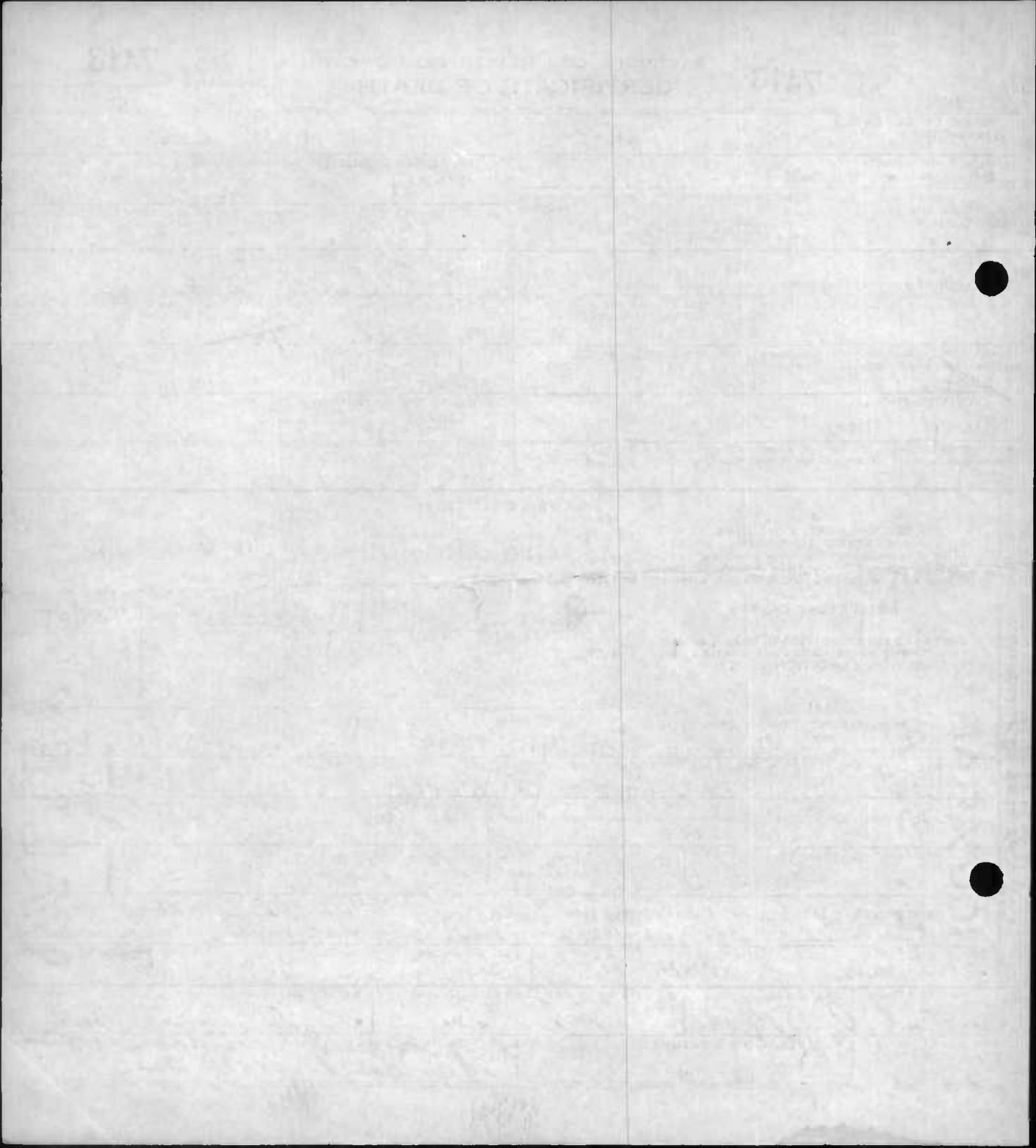
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>James David Morsell</u>		2. DATE OF DEATH <u>8-15-53</u>	
3. PLACE OF DEATH: A. <u>Baltimore City, Maryland</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md</u> B. COUNTY <u>Balt</u>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <u>Provident Hosp.</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Balt.</u> <u>12-03</u>	
D. STREET ADDRESS (If rural, give location) <u>807 Edmunson Ave</u>		E. LENGTH OF STAY IN BALTIMORE <u>Life</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>m</u>	8. DATE OF BIRTH <u>Apr 8 1878</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>upholsterer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>self</u>	
13. FATHER'S NAME <u>Benj. Morsell</u>		11. BIRTHPLACE (State or foreign country) <u>Balt md</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>unk</u>		16. SOCIAL SECURITY NO.	
14. MOTHER'S MAIDEN NAME <u>Mary</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
17. INFORMANT <u>Hosp. Records</u>		ADDRESS	

18. <u>420.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <u>Coronary Artery Heart Disease</u> DUE TO (B) <u>Generalized Arteriosclerosis</u> DUE TO (C) <u>Benign Prostatic Hypertrophy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>undet.</u> <u>undet.</u> <u>undet.</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <u>7-30-53</u>	19B. MAJOR FINDINGS OF OPERATION <u>Benign Pros Hypertrophy</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>7-22-</u> , 19 <u>53</u> , to <u>8-15</u> , 19 <u>53</u> ; that I last saw the deceased alive on <u>8-15</u> , 19 <u>53</u> , and that death occurred at <u>9:30 Am.</u> , from the causes and on the date stated above.				
23A. SIGNATURE <u>William L Farmer</u>		23B. ADDRESS <u>1574 Division St</u>		23C. DATE SIGNED <u>5/17/53</u>
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <u>Aug. 19, 1953</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Wm. Zim</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <u>Handing to Williams</u>	25. FUNERAL DIRECTOR <u>105, Druid Hill Ave.</u>		

MEDICAL CERTIFICATION

UG 15-150



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-650  
53 7414BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7414  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mattie Brown

2. DATE  
OF  
DEATH

Aug. 15, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, or institution: residence

A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

1925 W. Fairmount Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 20-01

D. STREET ADDRESS (If rural, give location)

1925 W. Fairmount Ave.

c. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Sept 15, 1899

9. AGE (in years last birthday)

53

10. Under 1 Year Months: Days

53

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

Dom. family

11. BIRTHPLACE (State or foreign country)

Gloucester, Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Silas Berry

14. MOTHER'S MAIDEN NAME

Mrs. Mattie C. Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

No

17. ADDRESS

1925 W. Fairmount Ave.

1B.

241X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure

5 wks.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Bronchial Asthma (status asthmaticus)

5 yrs.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/22 1948 to 8/16 1953, that I last saw the deceased alive on 8/7 1953, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

J. Preston Grant

23B. ADDRESS

601 N. Carrollton

23C. DATE SIGNED

8/18/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 19, 1953

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

1953

REGISTRAR'S SIGNATURE

[Signature]

25. FUNERAL DIRECTOR

[Signature]

ADDRESS

1601 W. Fairmount Ave.

VS 150

7208A

1117 85

1117 85

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAR-173386 500

BIRTH NO.

53 7415

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

53 7415

1. NAME OF DECEASED (Type or Print) <b>Mary Elizabeth Queen</b>			2. DATE OF DEATH <b>Aug. 16, 1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <b>Baltimore City Hospital</b> <b>4940 Eastern Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
D. STREET ADDRESS (If rural, give location) <b>1105 W. Franklin St. zone 23</b>			E. LENGTH OF STAY IN BALTIMORE <b>20 yrs.</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Wid.</b>	8. DATE OF BIRTH <b>Nov. 22, 1886</b>		9. AGE (In years last birthday) <b>66</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Joseph Parker</b>			14. MOTHER'S MAIDEN NAME <b>Manda ?</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>B. C. H. 4940 Eastern Ave. (records)</b>		
18. <b>570.5 and E902.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Intestinal Obstruction</b>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			CERTIFICATION APPROVED BY <b>William H. [Signature]</b> M.D. CHIEF OR ASST. MEDICAL EXAMINER		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<b>Sub-trochanteric fracture, right femur</b>		
19A. DATE OF OPERATION <b>8-10-53</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1105 W. Franklin St.</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>8-10-53</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fell out of bed</b>	
22. I hereby certify that I attended the deceased from <b>8-13</b> , 19 <b>53</b> , to <b>8-16</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>8-16</b> , 19 <b>53</b> , and that death occurred at <b>4:30 A.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>H. [Signature]</b>		23B. ADDRESS <b>4940 Eastern Ave., Balto., Md.</b>		23C. DATE SIGNED <b>8-16-1953</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>8/20/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>	
24D. LOCATION (City, town, or county) (State) <b>Annapolis, Md</b>		24E. DATE RECEIVED BY LOCAL REGISTRAR <b>8/19/53</b>		24F. REGISTRAR'S SIGNATURE <b>W. [Signature]</b>	
25. FUNERAL DIRECTOR <b>W. [Signature]</b>		ADDRESS <b>108 W. Washington</b> <b>Annapolis, Md</b>			

VS 150

To be approved by Medical Examiner

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B-514

53 7416

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7416

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Mary E. Bonneville

2. DATE  
OF  
DEATH

Aug. 17, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

South Balto. General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
Baltimore township) 20-02

D. STREET ADDRESS (If rural, give location)

2530 W. Fayette Street

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Dec. 28, 1890

9. AGE (In years  
last birthday)

62

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

seamstress

10B. KIND OF BUSINESS OR  
INDUSTRY

clothing mfg.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

James Bonneville

14. MOTHER'S MAIDEN NAME

Isabelle Webster

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

none

16. SOCIAL  
SECURITY NO.

213-01-9668

17. INFORMANT

ADDRESS

Helen Louell 2530 W. Fayette St.

18. 157X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION

malignant growth, head of pancreas

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 12, 1953, to Aug. 17, 1953, that I last saw the  
deceased alive on Aug. 17, 1953, and that death occurred at 5:20 a.m., from the causes and on the date stated above.

23A. SIGNATURE

S. W. M.

M. D.

23B. ADDRESS

SOUTH BALTIMORE GENERAL HOSP.

23C. DATE SIGNED

Aug. 17, 1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

Aug. 19, 1953

24C. NAME OF CEMETERY OR CREMATORY

Pine Grove

24D. LOCATION (City, town, or county)

Mt. Airey, Maryland

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

ADDRESS

George L. Schwab 2101 Frederick Ave.

188

188

188

188



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

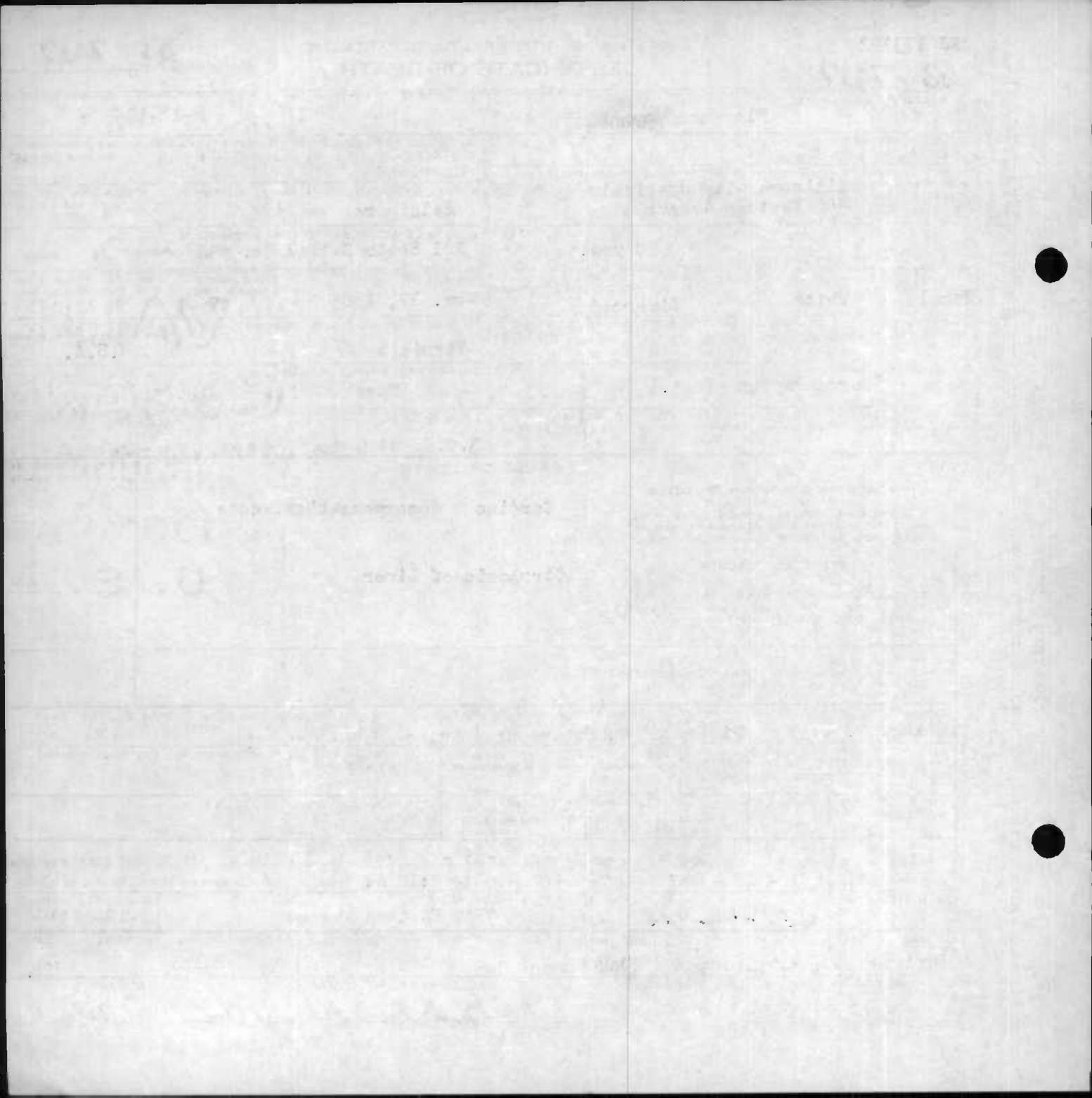
FJ 173102

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7417

BIRTH NO. 53 7417

1. NAME OF DECEASED (Type or Print) <b>Florence H. Branhan</b>		2. DATE OF DEATH <b>8-18-1953</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>X</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>3-01</b>	
c. Length of stay in Baltimore <b>30 yrs.</b>		D. STREET ADDRESS (If rural, give location) <b>221 South Dallas Ct. #30</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>Nov. 17, 1885</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (in years last birthday) <b>67</b> If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Monroe Payton (dec.)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. MOTHER'S MAIDEN NAME <b>Martha Britton (dec.)</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>B.C.H. 4940 Eastern Ave. (records)</b>	
18. <b>581.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cardiac decompensation, Acute</b> DUE TO <b>Cirrhosis of Liver</b> DUE TO <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>Aug. 7, 1953</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Biopsy of Subcutaneous Nodules</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <b>8-5-</b> , 1953, to <b>8-18-</b> , 1953, that I last saw the deceased alive on <b>8-18-</b> , 1953, and that death occurred at <b>2:10 A.M.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>H. J. [Signature]</b> M. O.		23B. ADDRESS <b>4940 Eastern Avenue</b>	
23C. DATE SIGNED <b>8-18-1953</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-21-1953</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Balto Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 19 1953</b>		25. FUNERAL DIRECTOR ADDRESS <b>Specialist Funeral Home 7401 Belair Rd</b>	
REGISTRAR'S SIGNATURE <b>[Signature]</b>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-152

53 7418

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7418

Registered No.

1. NAME OF DECEASED (Type or Print) <b>Edward T. Buffington</b>			2. DATE OF DEATH <b>August 16, 1953</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1403 Morling Avenue</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
C. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>1403 Morling Avenue</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>March 6, 1882</b>	9. AGE (In years last birthday) <b>71</b>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bal-Mar Corp.</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Frederick Buffington</b>			14. MOTHER'S MAIDEN NAME <b>Josephine Burkins</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-10-7248</b>	17. INFORMANT ADDRESS <b>Mrs. Dora E. Buffington 1403 Morling Ave</b>		
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary occlusion</b> DUE TO <b>Coronary Heart Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>2 years</b>			INTERVAL BETWEEN ONSET AND DEATH <b>July 24/53</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Nov 16, 1952</b> , to <b>Aug 16, 1953</b> that I last saw the deceased alive on <b>Aug 16, 1953</b> , and that death occurred at <b>10.45 p.m.</b> from the causes and on the date stated above.					
23A. SIGNATURE <b>Leonard Wallenstein</b>		23B. ADDRESS <b>848 W 36th St</b>		23C. DATE SIGNED <b>8/15/53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 20, 1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>	
24D. LOCATION (City, town, or county) <b>Baltimore Co., Maryland</b>		25. FUNERAL DIRECTOR ADDRESS <b>Burgee Funeral Home 3631 Falls Road</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 19 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington</b>		26. SIGNATURE <b>Horace F. Burgee</b>	

Age Group	Percentage of Respondents
18-29	85%
30-49	80%
50-69	75%
70+	70%



E-526

53 7419

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH83 7419  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>Bessie V. Ensor</b>		2. DATE OF DEATH <b>August 16<sup>th</sup> 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-14</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <b>Baltimore</b>	
D. STREET ADDRESS (If rural, give location) <b>1104 Woodheight Ave</b>		E. LENGTH OF STAY IN BALTIMORE <b>1 day</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>March 8<sup>th</sup> 1888</b>
9. AGE (In years last birthday) <b>65 y</b>		10. AGE (In years last birthday) <b>65 y</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John W. Keller</b>		14. MOTHER'S MAIDEN NAME <b>Mary Gorsuch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>2-18-375281</b>	
17. INFORMANT <b>Samuel J. Ensor</b>		ADDRESS <b>1104 Woodheight Ave</b>	
18. <b>420.0 and 260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarction</b> DUE TO <b>Arteriosclerotic heart disease.</b> DUE TO <b>Diabetes mellitus.</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Diabetes mellitus.</b>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>Aug 20 1953</b>		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>AUG 16<sup>th</sup> 1953</b> , to <b>AUG 16<sup>th</sup> 1953</b> that I last saw the deceased alive on <b>AUG 16<sup>th</sup> 1953</b> , and that death occurred at <b>9:15 p.m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>William J. Fetter</b>		23B. ADDRESS <b>Fetter W. J. Union Memorial Hosp. P-16-53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug 20 1953</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Green Grove</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 18 1953</b>		REGISTRAR'S SIGNATURE <b>Thurston W. Hall</b>	
25. FUNERAL DIRECTOR <b>Horace F. Burgee</b>		ADDRESS <b>3631 Fells Rd</b>	

MEDICAL CERTIFICATION

STATE OF NEW YORK  
CERTIFICATE OF DEATH

1900

1901

1902

1903

1904

1905

1906

1907

1908

1909

1910

1911

1912

1913

1914

1915

1916

1917

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

R-100  
7420

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7420  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>William H. Raab</i>		2. DATE OF DEATH <i>8/18-53</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>BALTIMORE 9-07</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>UNIVERSITY HOSPITAL</i>		D. STREET ADDRESS (If rural, give location) <i>1704 CARSWELL ST. #18</i>		LIFE TIME RESIDENT IN MD. Yrs. Mos. Days	
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>TRANSIT OPER.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>TRANSPORTATION</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
13. FATHER'S NAME <i>HENRY Raab</i>		14. MOTHER'S MAIDEN NAME <i>ELIZABETH DEPFER</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>UNKNOWN</i>		16. SOCIAL SECURITY NO. <i>213-05-9537</i>		17. INFORMANT ADDRESS <i>Mrs. ELIZ. I. Raab SANC</i>	
18. <i>610X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>CORONARY HEART DISEASE</i>		CAUSE OF DEATH (A) DUE TO <i>ARTERIOSCLEROSIS</i> (B) DUE TO <i>SUPRA-PUBIC PROSTATECTOMY</i> (C) <i>7/21/53</i>		INTERVAL BETWEEN ONSET AND DEATH <i>18 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>7/13/53</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>BENIGN PROSTATIC HYPERTROPHY</i>		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART II	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Aug 3, 1953</i> to <i>Aug 18, 1953</i> that I last saw the deceased alive on <i>Aug 18, 1953</i> , and that death occurred at <i>6:51 a. m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Robert J. Singleton, D.</i>		23B. ADDRESS <i>University Hospital</i>		23C. DATE SIGNED <i>8/18/53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-21-53</i>		24C. NAME OF CEMETERY OR CREMATORY <i>MT. OLIVET</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTO MD</i>		25. FUNERAL DIRECTOR <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 19 1953</i>		REGISTRAR'S SIGNATURE <i>Frederick W. ...</i>		VS 150 <i>69052</i>	

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **53 7421**

BIRTH NO. <b>53 7421 53-19150</b>			
1. NAME OF DECEASED (Type or Print) <b>BABY GIRL SHILLING</b>		2. DATE OF DEATH <b>Aug. 17/53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>md</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Singer Hospital of Baltimore, Inc</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 8-06</b>	
D. LENGTH OF STAY IN BALTIMORE <b>42</b>		D. STREET ADDRESS (If rural, give location) <b>1702 N. Chapel St #13</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>S</b>	8. DATE OF BIRTH <b>Aug. 17/53</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13. FATHER'S NAME <b>Edward William Schilling</b>		14. MOTHER'S MAIDEN NAME <b>Baumgartner - Marie Eckert</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>mother</b>		ADDRESS <b>above</b>	
18. <b>776x I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Prematurity</b> DUE TO (A) <b>Prematurity</b> DUE TO (B) <b>Prematurity</b> DUE TO (C) <b>Prematurity</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Cerebral angina</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Aug. 17, 1953</b> , to <b>Aug. 17, 1953</b> , that I last saw the deceased alive on <b>Aug. 17 1953</b> , and that death occurred at <b>3:10 a.m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>P. Schaffer</b>		23B. ADDRESS <b>Singer Hospital, Baltimore</b>	
23C. DATE SIGNED <b>Aug. 17/53</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-19-53</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery Baltimore Md</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 19 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>	
25. FUNERAL DIRECTOR <b>Glenn B. Winkler</b>		ADDRESS <b>924 E. Eagle St</b>	

STATE OF DEATH

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STATE OF DEATH

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

L-520

7422

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7422

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>John F. Lang</i>		2. DATE OF DEATH <i>August 18, 1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		D. STREET ADDRESS (If rural, give location) <i>2226 Lake Ave.</i>		5. AGE (In years last birthday) <i>72</i>	
c. Length of stay in Baltimore Yrs. <i>22</i> Mos. <i>2</i> Days <i>26</i>		6. DATE OF BIRTH <i>11-4-80</i>		9. AGE (In years last birthday) <i>72</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Spanners Point</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Christian Lang</i>		14. MOTHER'S MAIDEN NAME <i>Not known</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>		ADDRESS	
18. <i>443X</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Baileys Arteriosclerosis</i>			
DUE TO		(B) <i>Hypertension with atherosclerosis of the coronary arteries</i>			
DUE TO		(C)			
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <i>8-8</i> , 1953, to <i>8-18</i> , 1953, that I last saw the deceased alive on <i>8-18</i> , 1953, and that death occurred at <i>5:30 p.m.</i> , from the causes and on the date stated above.		23A. SIGNATURE <i>Edmund L. Abrahamson</i>	
23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>18 August 1953</i>		24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
24B. DATE <i>Aug. 22-53</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore Gen.</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>John H. Miller</i>		FURNERAL DIRECTOR <i>2334 Jefferson St.</i>	

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THE UNIVERSITY OF CHICAGO PRESS  
CHICAGO, ILL. 60607

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*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

P-160  
53 7423

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7423

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Emma E. Pfeifer</i>		2. DATE OF DEATH <i>Aug. 16-1953</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY		
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>500 N. Montford Ave.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto. 7-03</i>		
6. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>500 N. Montford Ave.</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>April 15-1999</i>	
9. AGE (in years last birthday) <i>54</i>		10. UNDER 1 Year Months: Days Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Jarven Operator</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Jarven</i>		
11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Benedict Pfeifer</i>		14. MOTHER'S MAIDEN NAME <i>Sophia Roemer</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Wm. Pfeifer</i>		ADDRESS <i>4113 2<sup>nd</sup> Ave.</i>		
18. 158X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Myocardial Degeneration</i> DUE TO (B) <i>Carcinoma - Urterostatic -</i> DUE TO <i>peritoneal</i> (C)		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>April 10, 1952</i> to <i>Aug. 16, 1953</i> , that I last saw the deceased alive on <i>Aug. 10, 1953</i> , and that death occurred at <i>2 P</i> m., from the causes and on the date stated above.				
23A. SIGNATURE <i>E. A. Flanagan Jr.</i>		23B. ADDRESS <i>3501 Fair Ave</i>		23C. DATE SIGNED <i>8-18-53</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Aug. 21/53</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Cash Lawn Cem.</i>
24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>		25. FUNERAL DIRECTOR <i>John R. Miller</i>		
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		ADDRESS <i>2334 Jefferson St.</i>

VS 150

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MEDICAL CERTIFICATION

THE MARITIME COMMISSIONER  
WASHINGTON, D. C.

W-420  
742453-17825

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7424  
Registered No.

1. NAME OF DECEASED (Type or Print) Infant of Thelma Wallace		2. DATE OF DEATH July 15, 1953	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel	
5. FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bristol 5200	
6. DATE OF BIRTH July 15, 1953		9. AGE (In years last birthday) 3 10. Under 1 Year Months: Days 3 11. Under 24 Hours Hours: Min. 10	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Benjamin Wallace		14. MOTHER'S MAIDEN NAME Thelma Tovola Wallace	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		ADDRESS	

18. 762.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) Anoxia		DUE TO			
ANTECEDENT CAUSES		(B) Scurvy			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 15th, 1953 to July 15th, 1953 that I last saw the deceased alive on July 15th, 1953 and that death occurred at 5:41 p.m., from the causes and on the date stated above.					
23A. SIGNATURE [Signature]		23B. ADDRESS The Johns Hopkins Hospital		23C. DATE SIGNED 8/4/53	

24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY Hosp Desford		24D. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR AUG 19 1953		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR 7425		ADDRESS	

1917

1917



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **53 7425**

**W-623**  
**53 7425**  
**33-17/21**

1. NAME OF DECEASED (Type or Print) <b>Infant of Elizabeth Wright (291501)</b>		2. DATE OF DEATH <b>July 16, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>The Johns Hopkins Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
6. Length of stay in Baltimore <b>Infant</b>		D. STREET ADDRESS (If rural, give location) <b>2418 Madison Avenue - 17</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>July 16, 1953</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>Charles Speight</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <b>Hospital Records</b>	
		ADDRESS	

18. <b>761.0</b> I <b>CAUSE OF DEATH</b>		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Anoxia</b> (A) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Abruption placenta</b> (B) DUE TO		
(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 16th, 1953</b> , to <b>July 16th, 1953</b> that I last saw the deceased alive on <b>July 16th, 1953</b> and that death occurred at <b>4.35 P.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <i>[Signature]</i>		23B. ADDRESS <b>The Johns Hopkins Hospital</b>		23C. DATE SIGNED <b>7/28/53</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 19 1953</b>		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR <b>7 4 2 6</b>		ADDRESS	

MEDICAL CERTIFICATION

1915-16

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done by the various departments and a statement of the results achieved. It is a very important part of the report and should be read carefully.

2. The second part of the report deals with the details of the work done by the various departments. It is a very detailed account of the work done and should be read carefully.

3. The third part of the report deals with the financial statement of the year. It is a statement of the income and expenditure of the year and should be read carefully.

4. The fourth part of the report deals with the general remarks of the year. It is a statement of the progress of the work and a statement of the results achieved. It is a very important part of the report and should be read carefully.

5. The fifth part of the report deals with the general remarks of the year. It is a statement of the progress of the work and a statement of the results achieved. It is a very important part of the report and should be read carefully.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7427

T534627  
BIRTH NO. 53-14035

1. NAME OF DECEASED  
(Type or Print)

Baby Girl Taylor (Flora)

2. DATE OF DEATH

July 7, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore 2

D. STREET ADDRESS (If rural, give location)

104 N. Bond St.

5. Length of stay in Baltimore

Yrs.  
Mos.  
Days

SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

6-20-53

9. AGE (In years last birthday)

6 wks

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Flora

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 754.4

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Conjugal Genital Heart Disease

ANTECEDENT CAUSES

(B)

Aspiration

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Left Palate & Hair Lips

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-20-1953 to 8-7-1953 that I last saw the deceased alive on 8-7-1953 and that death occurred at 9:00 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Herman Pichler Jr.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

7 Aug 53

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 1 9 1953

Hunter 55/31000167

7 4 2 8

Hospital Disposal

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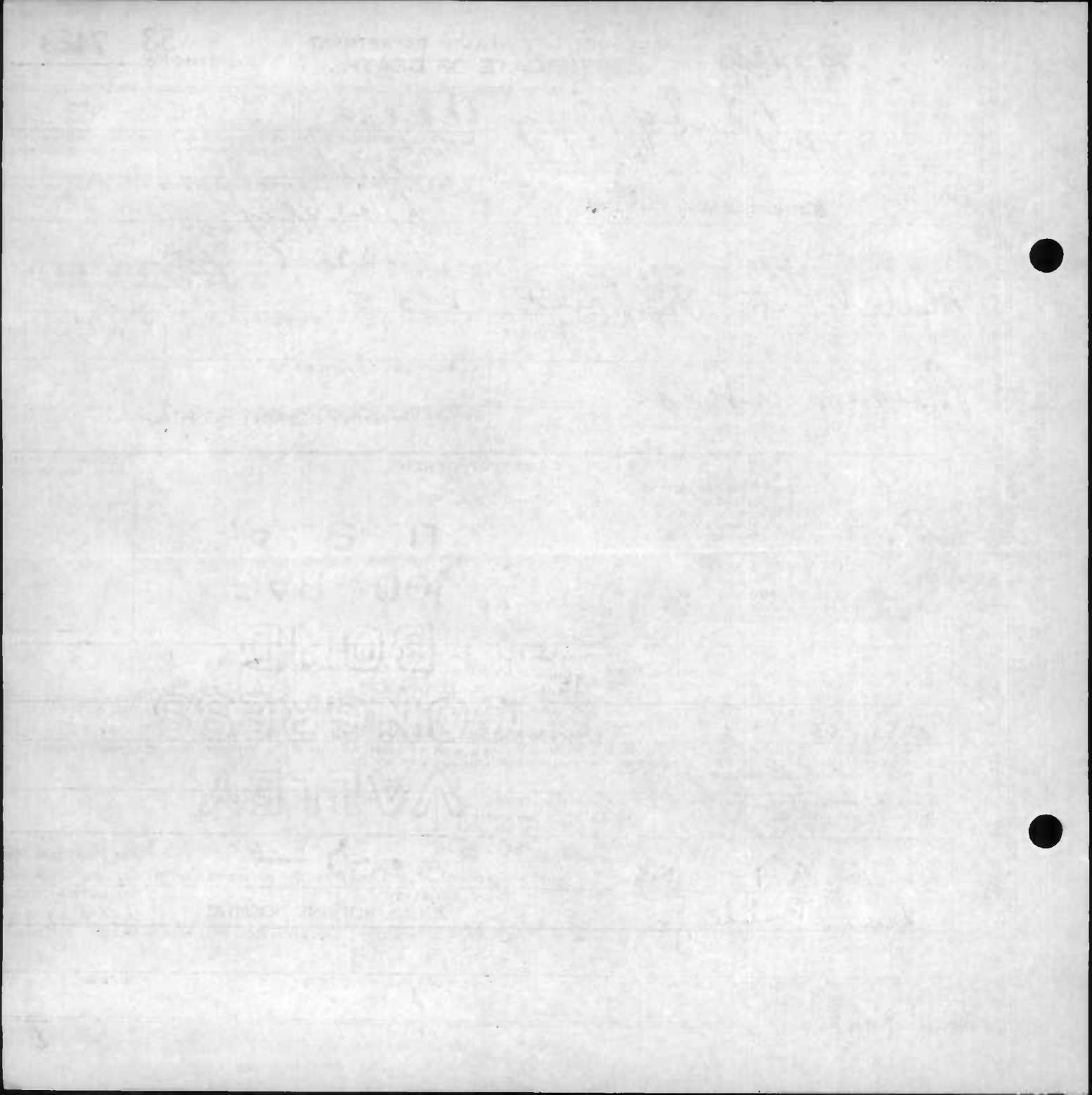
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO. 23-18634		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		53 7428 Registered No.	
1. NAME OF DECEASED (Type or Print) <b>Baby Boy Akers</b>			2. DATE OF DEATH <b>AUG 9 - 1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>10 L H 4E</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Anne Arundel</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Grosse Pointe</b>		
D. STREET ADDRESS (If rural, give location) <b>Farrest Ave</b>			E. ZIP CODE <b>6200</b>		
5. Length of stay in Baltimore Yrs. Mos. Days			6. DATE OF BIRTH <b>8-3-53</b>		
7. SEX <b>Male</b>			8. AGE (In years last birthday) <b>6</b>		
9. COLOR OR RACE <b>White</b>			10. Under 1 Year Months: Days: <b>6</b>		
11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Infant</b>			12. Under 24 Hours Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME <b>Roger Akers</b>			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>JOHNS HOPKINS HOSPITAL</b>			ADDRESS		
18. 756.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>			CAUSE OF DEATH <b>Pneumonia</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>multiple. anomalies - spine lipids - meningococci - myelom. coal. str. &amp; gall bladder. Acute myel. leuk.</b>					
19A. DATE OF OPERATION <b>5 Aug 53</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>chuck for prostate cancer</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			21D. HOW DID INJURY OCCUR?		
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY m. WHILE AT WORK NOT WHILE AT WORK					
22. I hereby certify that I attended the deceased from <b>8-5-</b> 19 <b>53</b> to <b>8-9-</b> 19 <b>53</b> , that I last saw the deceased alive on <b>8-9-</b> 19 <b>53</b> and that death occurred at <b>3:20</b> m. from the causes and on the date stated above.					
23A. SIGNATURE <b>Kernow P. White Jr.</b>			23B. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>		
24A. BURIAL, CREMATION, REMOVAL (Specify)			24B. DATE		
24C. NAME OF CEMETERY OR CREMATORY <b>Hopk. Burial</b>			24D. LOCATION (City, town, or county) (State)		
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 19 1953</b>			REGISTRAR'S SIGNATURE <b>Huntington</b>		
25. FUNERAL DIRECTOR <b>7429</b>			ADDRESS		



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO.

53 7429

# BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 53 7429

1. NAME OF DECEASED  
(Type or Print)

Baby Marianna Warner

2. DATE  
OF  
DEATH

Aug. 13, '53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

H. S. Pre

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Ind.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION: JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore - 15-10

D. STREET ADDRESS (If rural, give location)

4112 Oakford Ave -

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female White

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

8-9-53

9. AGE (In years last birthday)

10. Under 1 Year  
Months: Days: Hours: Min.

4

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ind -

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Marianna ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18. 776x  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

(A) Prematurity  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?  
YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-9, 1953 to 8-13, 1953 that I last saw the deceased alive on 8-15, 1953, and that death occurred at 8-0 m., from the causes and on the date stated above.

23A. SIGNATURE

C. Morgan M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

8/13/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

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# Hospital Disposal

## BALTIMORE CITY HEALTH DEPARTMENT

### CERTIFICATE OF DEATH

Registered No. 53 7430

BIRTH NO. 53 7430 33-20062

1. NAME OF DECEASED  
(Type or Print)

Baby-- Sally Long

2. DATE  
OF  
DEATH

Aug-16-1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY.

B. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 5-01

D. STREET ADDRESS (If rural, give location)

115 N. Exeter St

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

S.

8. DATE OF BIRTH

8-16-53

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Sally

Long

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

JOHNS HOPKINS HOSPITAL

ADDRESS

18. 761.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Cerebral anoxia and hemorrhage

24 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Uterine inertia &amp; prolapse of cord

DUE TO

(C)

II

OTHER SIGNIFICANT CONOITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-15-1953 to 8-16-1953 that I last saw the  
deceased alive on 8-16-1953 and that death occurred at 11:26 Pm., from the causes and on the date stated above.

23A. SIGNATURE

Harmon P. White Jr.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

17 Aug 53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

Hosp Disposal

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS



100-1000

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P-536

53 7431 63-19501

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7431

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Baby boy Painter</i>		2. DATE OF DEATH <i>8/19/53</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore Gen Hosp.</i>		C. CITY OR TOWN (If outside corporate limits, write R.U.A. and give township) <i>Baltimore 25-05</i>	
C. Length of stay in Baltimore <i>1 day</i>		D. STREET ADDRESS (If rural, give location) <i>4710 CURTIS Ave.</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>8/18/53</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <i>Charles Painter</i>		14. MOTHER'S MAIDEN NAME <i>Evelyn C. Foster</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	

18. <i>752X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Cerebral anoxia</i>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO <i>Hydrocephalia</i>		
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>8/18/53</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>8/18</i> , 1953 to <i>8/19</i> , 1953, that I last saw the deceased alive on <i>8/19</i> , 1953, and that death occurred at <i>7 P. m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Dr. O. Probst</i>		23B. ADDRESS <i>M. D. 1213 Light St. Balt., Md.</i>		23C. DATE SIGNED <i>8/19/53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>8-18-53</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mount Royal Va.</i>	
24D. LOCATION (City, town, or county) (State) <i>Va</i>		25. FUNERAL DIRECTOR <i>Thurmond C. Hale</i>			
DATE RECEIVED BY LOCAL REGISTRAR <i>VS 201953</i>		REGISTRAR'S SIGNATURE <i>Thurmond C. Hale</i>		ADDRESS <i>131 E West St</i>	

MEDICAL CERTIFICATION

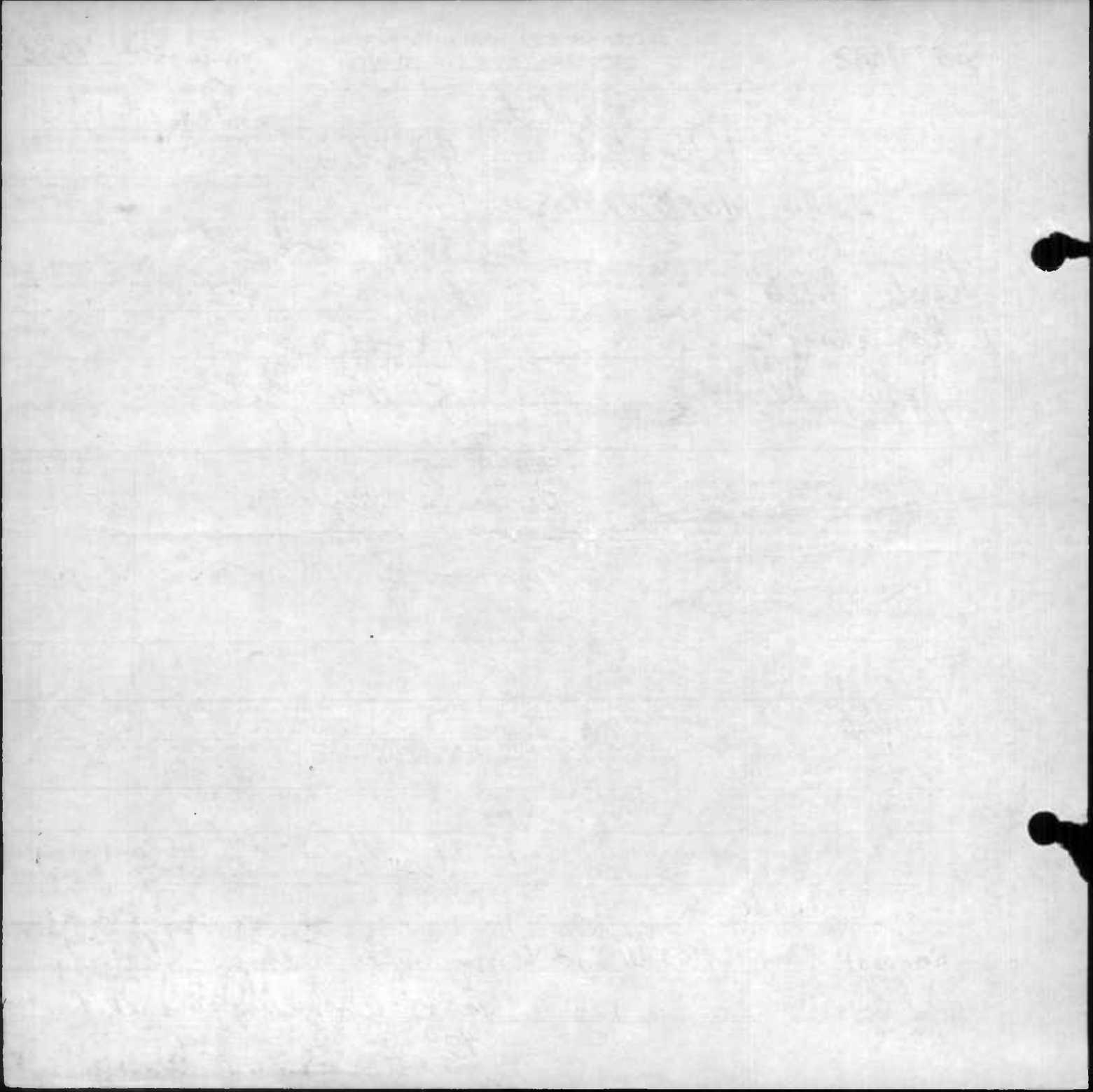
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2-8160

4710 Charles Ave

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. <b>53 7432</b>	
1. NAME OF DECEASED (Type or Print) <b>Evelyn Radd</b>			2. DATE OF DEATH <b>Aug-19-1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Halsted 6</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Florida</b> B. COUNTY <b>V-08</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSP.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Tampa</b>		
C. Length of stay in Baltimore <b>33</b> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>3814 58th St.</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>12-10-09</b>	
13. FATHER'S NAME <b>John Wood</b>		11. BIRTH PLACE (State or foreign country) <b>Florida</b>		9. AGE (In years last birthday) <b>43</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY?	
17. INFORMANT <b>Ruby Gill</b>		ADDRESS <b>✓</b>			
18. <b>410X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>(A) Ventricular fibrillation</b> DUE TO ANTECEDENT CAUSES <b>(B) myxoma of left auricle</b> DUE TO <b>(C)</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1+ min.</b> <b>1+ yr.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT.					
19A. DATE OF OPERATION <b>8/19/53</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>mitral stenosis</b>		IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7-27-1953</b> , to <b>8-19-1953</b> , that I last saw the deceased alive on <b>8-19-1953</b> , and that death occurred at <b>9:35</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>J. C. Cordell, Jr.</b>		23B. ADDRESS		23C. DATE SIGNED <b>8/19/53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>Aug. 19, 1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Wilson Sammon Co</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 20 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington</b>		24D. LOCATION (City, town, or county) (State) <b>Tampa - Florida</b>	
25. FUNERAL DIRECTOR <b>Earl B. Woberton Funeral Home, Inc.</b>		ADDRESS <b>403-E-25th Street Baltimore - 18 - Maryland</b>			



Hospital Disposal		ALC-53-11512		BALTIMORE CITY HEALTH DEPARTMENT		53 7433		Registered No. 53 7433	
BIRTH NO.		53 7433		CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)				2. DATE OF DEATH					
Nettie Waldon				Aug. 8, 1953					
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
D. J. A. 4 W				A. STATE				B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION				C. CITY OR TOWN				(If outside corporate limits, write RURAL and give township)	
JOHNS HOPKINS HOSPITAL				Baltimore				14-02	
c. Length of stay in Baltimore				D. STREET ADDRESS (If rural, give location)					
Yrs. Mos. Days				1523 Pennsylvania Ave					
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		Colored		Single		6-21-1953		2	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)	
								12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
William H. Waldron									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS	
(If yes, give war or dates of service)								JOHNS HOPKINS HOSPITAL	
18. 754.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(A) Congenital Heart Disease				DUE TO					
ANTECEDENT CAUSES				(B) Truncus Arteriosus					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				DUE TO					
(C)									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 7/30, 1953, to 8/8, 1953, that I last saw the deceased alive on 8/8, 1953, and that death occurred at 11.00 p.m., from the causes and on the date stated above.									
23A. SIGNATURE Margaret D. Bailey, D.				23B. ADDRESS JOHNS HOPKINS HOSPITAL				23C. DATE SIGNED 8/9/53	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county)		(State)	
				Hospital Disposal					
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR		ADDRESS			
AUG 20 1953		Huntington 5550 7434							

1875-1876

1

Good night to you

Yours truly

Wm. H. H.

Wm. H. H.

Wm. H. H.

Wm. H. H.

Wm. H. H.

Wm. H. H.



522  
7434

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7434

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Rose Jankiewicz</b>		2. DATE OF DEATH <b>Aug. 18, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>103</b>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>2423 Foster Avenue</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>			
C. Length of stay in Baltimore <b>55 years</b>		D. STREET ADDRESS (If rural, give location) <b>2423 Foster Avenue</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>1870?</b>	9. AGE (In years last birthday) <b>83?</b>	10. If Under 1 Year: Months: Days; If Under 24 hours: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Poland</b>	
13. FATHER'S NAME <b>Pacena</b>		12. CITIZEN OF WHAT COUNTRY?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Andrew Jankiewicz - 2423 Foster Avenue</b>	
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> DUE TO <b>Chr Myocarditis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Generalized Arterio Sclerosis</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>Aug 17 53</b> <b>Aug 1 50</b> <b>Jan 1 44</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Aug 1, 1950</b> to <b>Aug 18, 1953</b> , that I last saw the deceased alive on <b>Aug 18, 1953</b> and that death occurred at <b>5:00 p.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>William R. Danner</b>		23B. ADDRESS <b>801 E. Greenwood St</b>		23C. DATE SIGNED <b>Aug 19 53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug 22, 1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>	
24D. LOCATION (City, town, or county) (State) <b>1300 Dundalk Ave Balto. Md</b>		25. FUNERAL DIRECTOR ADDRESS <b>George A. Weber</b>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth	
6. Date of death		7. Time of death		8. Cause of death		9. Manner of death		10. Signature of physician	
11. Signature of registrar		12. Signature of informant		13. Signature of witness		14. Signature of funeral director		15. Signature of undertaker	
16. Signature of coroner		17. Signature of jury		18. Signature of jury		19. Signature of jury		20. Signature of jury	
21. Signature of jury		22. Signature of jury		23. Signature of jury		24. Signature of jury		25. Signature of jury	
26. Signature of jury		27. Signature of jury		28. Signature of jury		29. Signature of jury		30. Signature of jury	
31. Signature of jury		32. Signature of jury		33. Signature of jury		34. Signature of jury		35. Signature of jury	
36. Signature of jury		37. Signature of jury		38. Signature of jury		39. Signature of jury		40. Signature of jury	
41. Signature of jury		42. Signature of jury		43. Signature of jury		44. Signature of jury		45. Signature of jury	
46. Signature of jury		47. Signature of jury		48. Signature of jury		49. Signature of jury		50. Signature of jury	
51. Signature of jury		52. Signature of jury		53. Signature of jury		54. Signature of jury		55. Signature of jury	
56. Signature of jury		57. Signature of jury		58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury		64. Signature of jury		65. Signature of jury	
66. Signature of jury		67. Signature of jury		68. Signature of jury		69. Signature of jury		70. Signature of jury	
71. Signature of jury		72. Signature of jury		73. Signature of jury		74. Signature of jury		75. Signature of jury	
76. Signature of jury		77. Signature of jury		78. Signature of jury		79. Signature of jury		80. Signature of jury	
81. Signature of jury		82. Signature of jury		83. Signature of jury		84. Signature of jury		85. Signature of jury	
86. Signature of jury		87. Signature of jury		88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury		94. Signature of jury		95. Signature of jury	
96. Signature of jury		97. Signature of jury		98. Signature of jury		99. Signature of jury		100. Signature of jury	

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **53 7435****K-155**  
**53 7435**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)*Louis Kaufman*2. DATE  
OF  
DEATH*Aug 19 1953*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or  
location)*Ana Hospital*C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)*Long Island (Bay Shore)*

D. STREET ADDRESS (If rural, give location)

*105 Third Avenue Long Island*

C. Length of stay in Baltimore

*5 weeks*Yrs.  
Mos.  
Days

5. SEX

*Male*

6. COLOR OR RACE

*White*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)*married*

8. DATE OF BIRTH

*March 18 1908*9. AGE (In years,  
last birthday)*45*H Under 1 Year  
Months: DaysH Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)*Farmer*10B. KIND OF BUSINESS OR  
INDUSTRY*?*

11. BIRTHPLACE (State or foreign country)

*Brooklyn, N. Y.*12. CITIZEN OF  
WHAT COUNTRY?*U.S.A.*

13. FATHER'S NAME

*John Kaufman*

14. MOTHER'S MAIDEN NAME

*Fannie Chesler*15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give year or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

*Mrs. Gussie Kaufman - Same*18. *602X and 260X*

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) *Uremia*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) *Diabetes Mellitus*

DUE TO

(C) *Constrictive heart failure*  
*Bright's disease*

II

OTHER SIGNIFICANT CONITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONITION CAUSING IT.

19A. DATE OF OPERATION

*Aug 4 1953*19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED*Calculus Rt. Kidney*IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐  
WORKNOT WHILE ☐  
AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *7-13*, 19*53*, to *8-19*, 19*53*, that I last saw the  
deceased alive on *8-19*, 19*53*, and that death occurred at *1:00* p.m., from the causes and on the date stated above.

23A. SIGNATURE

*Winston Locantore*

23B. ADDRESS

*Levin Corp.*

23C. DATE SIGNED

*Aug 19 1953*24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)*Burial*

24B. DATE

*8/23/53*

24C. NAME OF CEMETERY OR CREMATORY

*Mt. Aet*

24D. LOCATION (City, town, or county) (State)

*Bay Shore Long Is. New York*DATE RECEIVED BY  
LOCAL REGISTRAR*AUG 20 1953*

REGISTRAR'S SIGNATURE

*Huntington Williams, M.D.*

25. FUNERAL DIRECTOR

*Vol. Livingston & Bros. 1124 W. North Ave.*

VS 150

10010

23 MAY

ALPHABETICALLY BY LAST NAME

STATE OF DEATH

23 MAY

M-460

3 7436

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7436

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MORRIS MILLER

2. DATE  
OF  
DEATH

8-19-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

3012 West Garrison Ave Baltimore 27-17

C. Length of stay in Baltimore

Yrs. 62  
Mos.  
Days

5. SEX

Male

6. COLOR OF RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

9. AGE (in years last birthday)

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

74

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

mens Tailor

11. BIRTHPLACE (State or foreign country)

Latvia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Not Known

14. MOTHER'S MAIDEN NAME

Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Rose Miller - Same

18. 442X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

Cerebral Thrombosis

3 days

ANTECEDENT CAUSES

DUE TO

arteriosclerosis

(B)

Cornea Vascular Nerve Disease

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/8/53, to 8/19, 1953, that I last saw the deceased alive on 8/19, 1953, and that death occurred at 12:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Joseph S. Belum

M. D.

23B. ADDRESS

1154 Calver St

23C. DATE SIGNED

8/19/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-20-50

24C. NAME OF CEMETERY OR CREMATORY

B'nai Israel

24D. LOCATION (City, town, or county)

Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

ADDRESS

Jack Lewis 2100 Cutler Pl

VS 150

5906E

MEDICAL CERTIFICATION

Joe Blum  
1115 No Calvert

MW 4777

3513 Potomac Ave  
To 0444

---



53 17437 620

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7437  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Louis J. Myers

2. DATE  
OF  
DEATH

8. 19. 1953.

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore City

4. USUAL RESIDENCE (Where deceased lived. If institution; residence

A. STATE B. COUNTY before admission)

MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTE Sinai Hospital

C. CITY OR TOWN (If outside corporate limits, write full name and give township)

BALTO.

D. STREET ADDRESS (If rural, give location)

2207 LINDEN AVE

42 Length of stay in Baltimore

47

Yrs.  
Mos.  
Days

5. SEX

M.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

INSURANCE

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

RUSSIA

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ABBA

14. MOTHER'S MAIDEN NAME

SQRQH

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

MAX MYERS - 2419 CULLOW AVE

18. 422.1 and 181X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Acute cardiac insufficiency

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) A. S. C. V. D.

DUE TO

(C) Pulmonary embolism

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Carcinoma of bladder

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7. 22. 1953, to 8. 19. 1953, that I last saw the  
deceased alive on 8. 19. 1953, and that death occurred at 1:10 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Morris M. Goldberg

23B. ADDRESS

Sinai Hospital Balto. Md.

23C. DATE SIGNED

8. 19. 53.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 20, 1953

24C. NAME OF CEMETERY OR CREMATORY

Southern Ave

24D. LOCATION (City, town, or county)

Balto

(State)

Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 20 1953

Huntington, William, Jr. 2100 E. E. Ave PL

APR 14 1973

100-11450

State Hospital

Heart cordis insuff. cond.

A. S. C. V. D.

Pulmonary embolism

Carcinoma of bladder

1. 22. 8. 19

1973

8. 19. 73

Morris M. G. G. G.

State Hospital, Dallas, Texas

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7438

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 53 7438

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Benjamin Fisher

2. DATE  
OF  
DEATH

Aug 19, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Med. Center 6

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Md

C. CITY OR TOWN

(If outside corporate limits, write FULLAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1228 E. Baltimore St

c. Length of stay in Baltimore

Life

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Louis Fisher - 920 Channing Ave

18. 581.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Bleeding Esophageal Varices

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Laennec's Cirrhosis

DUE TO

(C) Chronic Alcoholism

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II20. AUTOPSY  
YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-18-, 1953 to 8-19-, 1953, that I last saw the  
deceased alive on 8-19-, 1953 and that death occurred at 3:35 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

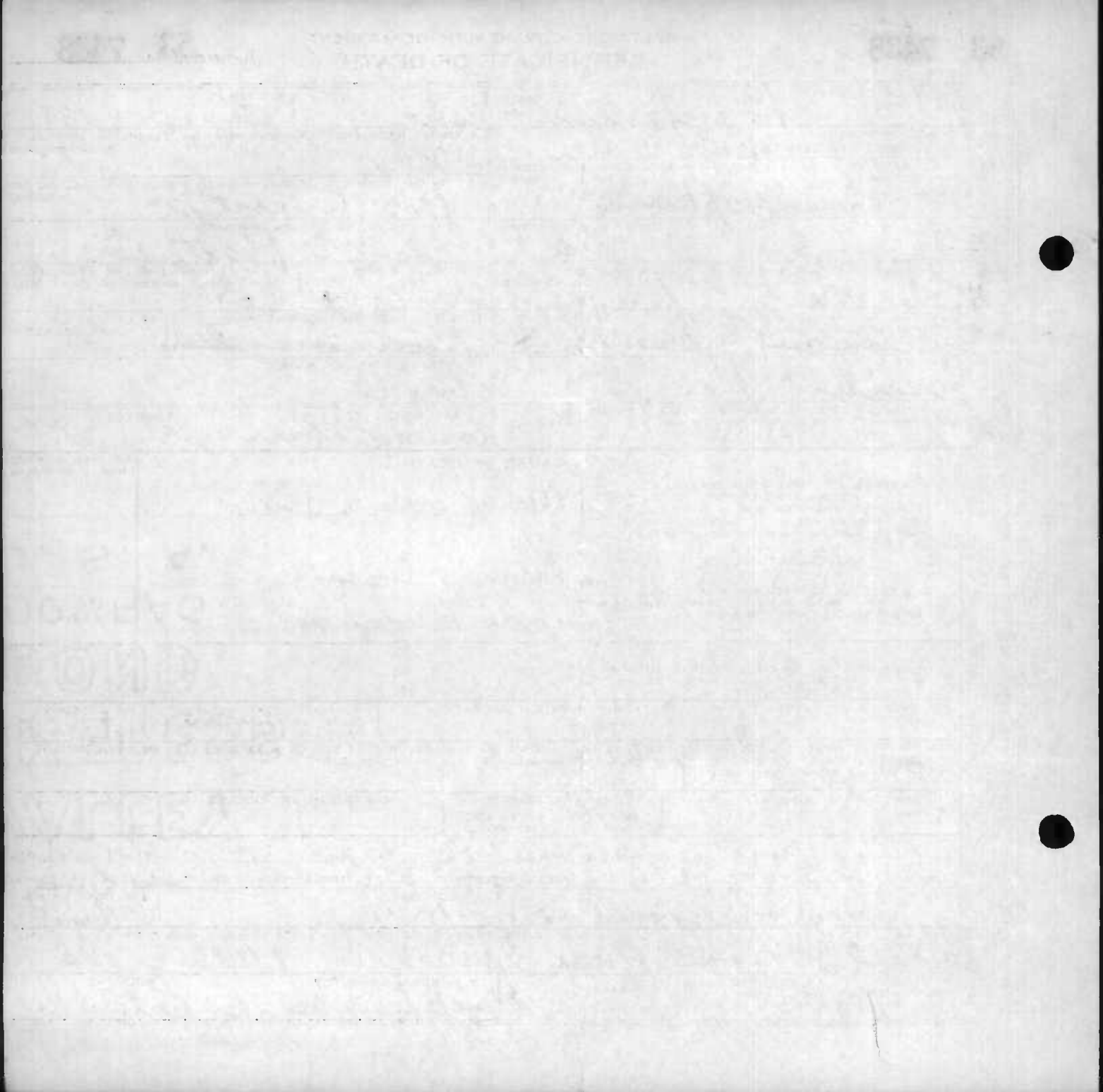
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



H-452  
53 7439BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7439

1. NAME OF DECEASED (Type or Print) <b>RICHARD W. Holmes</b>		2. DATE OF DEATH <b>8-18-1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>md</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>FRANKLIN SQUARE HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE - 19-04</b>	
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <b>310 S. FULTON AVE</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>MAR - 1886</b>
9. AGE (In years last birthday) <b>67</b>		10. Under 1 Year Months: Days If Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STATIONARY ENGINEER</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Holmes</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-10-0371</b>	
17. INFORMANT <b>JAMES FALTER</b>		ADDRESS <b>626 S. Payson St</b>	
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CORONARY THROMBOSIS</b> DUE TO <b>PROBABLY NORMAL AGING</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>	
19. DATE OF OPERATION <b>0</b> 19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) INJURY	
21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>aug. 1950</b> , 19 <b>50</b> , to <b>aug 18</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>Aug 17</b> , 19 <b>53</b> , and that death occurred at <b>11:30 Pm.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>M. B. Schriber</b>		23B. ADDRESS <b>548 E. ULTMARE</b>	
23C. DATE SIGNED <b>8-19-53</b>		23D. M. D.	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-21-53</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK Cem</b>		24D. LOCATION (City, town, or county) (State) <b>FREDERICK AVE. BALTO</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 20 1953</b>		REGISTRAR'S SIGNATURE <b>Thurington</b>	
25. FUNERAL DIRECTOR <b>Thomas J. Kenny</b>		ADDRESS <b>1600 Hollins St</b>	

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1947

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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

1949





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **53 7440**

BIRTH NO. <b>53 7440</b>		1. NAME OF DECEASED (Type or Print) <b>RANDOLPH</b>		2. DATE OF DEATH <b>August 16, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN <b>Md.</b> (If outside corporate limits, write RURAL and give township)	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>		D. STREET ADDRESS (If rural, give location) <b>341 Odella Avenue</b>		E. LENGTH OF STAY IN BALTIMORE Yrs. <b>38</b> Mos. <b>8</b> Days <b>8</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Sept. 16, 1920</b>	9. AGE (In years last birthday) <b>32</b>	10. UNDER 1 Year Months <b>0</b> Days <b>0</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Sykesville Md.</b>	
13. FATHER'S NAME <b>Andrew Corporal</b>		14. MOTHER'S MAIDEN NAME <b>Benerva Bassow</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Bernice Corporal</b>	
18. <b>E981X</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Gunshot wound of abdomen with</b> <b>xxxxx perforation of aorta</b>			
ANTECEDENT CAUSES		(B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>house</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>337 Odella Avenue</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>8-16-53 11:15 P.M.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>shot during altercation</b>	
22. I certify that I took charge of the remains described above, held an <b>autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>B. B. Fisher</b>		23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>8-17-53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 29, 1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Yllo Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Cella Md.</b>		25. FUNERAL DIRECTOR <b>Mrs. Kate R. Williams</b>		ADDRESS <b>3229 Schaeffer St.</b>	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7441

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7441

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARIAN

CHANNEY

Banks

2. DATE  
OF  
DEATH

August 19, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Baltimore City Morgue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

228 N. Stricker Street

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Feb. 20, 1937

9. AGE (In years  
last birthday)

16

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Atlanta Ga.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ernest Channey

4. MOTHER'S MAIDEN NAME

Aethia Banks

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mary Wilson 228 N. Stricker St.

18. 002X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Pulmonary tuberculosis, far advanced

DUE TO

## ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Joseph A. Jaume

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Aug. 19, 1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

1957 57

RECEIVED BY THE  
OFFICE OF THE  
SECRETARY OF THE  
NAVY

NAV 57

C-320

53 7442 53-18089

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7442

1. NAME OF DECEASED (Type or Print) <i>Wanda Coates</i>		2. DATE OF DEATH <i>Aug. 19, 1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>md.</i> B. COUNTY <i>20-02</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Provident Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto.</i>	
Length of stay in Baltimore <i>15</i> Yrs. <i>5</i> Mos. <i>0</i> Days		D. STREET ADDRESS (If rural, give location) <i>334 N. Pulaski St.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>Aug 5, 1953</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>15</i> If Under 1 Year: Months <i>15</i> Days <i>15</i> If Under 24 Hours: Hours <i>15</i> Min.
11. BIRTHPLACE (State or foreign country) <i>Balto. md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Walter Sherman Coates</i>		14. MOTHER'S MAIDEN NAME <i>Minnie Hawkins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mather</i>		ADDRESS <i>same address</i>	
18. <i>764.5</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Prematurity with secondary acute bacterial enteritis</i> DUE TO (A) <i>Prematurity with secondary acute bacterial enteritis</i> (B) <i>secondary acute bacterial enteritis</i> (C) <i>secondary acute bacterial enteritis</i> INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>8-15</i> , 1953, to <i>8-19</i> , 1953, that I last saw the deceased alive on <i>8-19</i> , 1953, and that death occurred at <i>3:55 a.m.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>Lorenzo Lopez md.</i>		23B. ADDRESS <i>Provident Hospital</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/21/53</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Balto. Nat. Cemetery</i>		24D. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 20 1953</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>	
25. FUNERAL DIRECTOR <i>Co. H. H. H. - 918 -</i>		ADDRESS <i>Reid Hill ave.</i>	

Tom Halstead



R-152  
53 7443BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7443  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH HENRY ROBINSON

2. DATE

OF

DEATH

AUG 18. 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland 736 MELVILLE

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

736 MELVILLE AVE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write full name and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

720 S. POTOMAC ST

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

WIDOWED

Yrs.

Mos.

Days

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

CARPENTER FOREMAN - OIL CO

10B. KIND OF BUSINESS OR  
INDUSTRY

8. DATE OF BIRTH

MAR. 19. 1873

9. AGE (In years  
last birthday)

80

11 Under 1 Year

Months Days

11 Under 24 Hours

Hours Min.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JAMES ROBINSON

14. MOTHER'S MAIDEN NAME

BARBARA COLLINS

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

—

17. INFORMANT

ADDRESS

JOSEPH R. ROBINSON 720 S. POTOMAC

18. 450-0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Arterio-sclerosis

57 yrs.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the  
deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL

AUG 21. 1953

OAK LAWN

COLGATE

MD

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS 2112

AUG 20 1953

J. H. R. 5/3/53

ULRICH FUNERAL HOME PUNDAUR

*[Faint, illegible text throughout the page, likely bleed-through from the reverse side. Some faint words like "WHEREAS" and "AND" are visible.]*

M-440  
3 7444  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7444

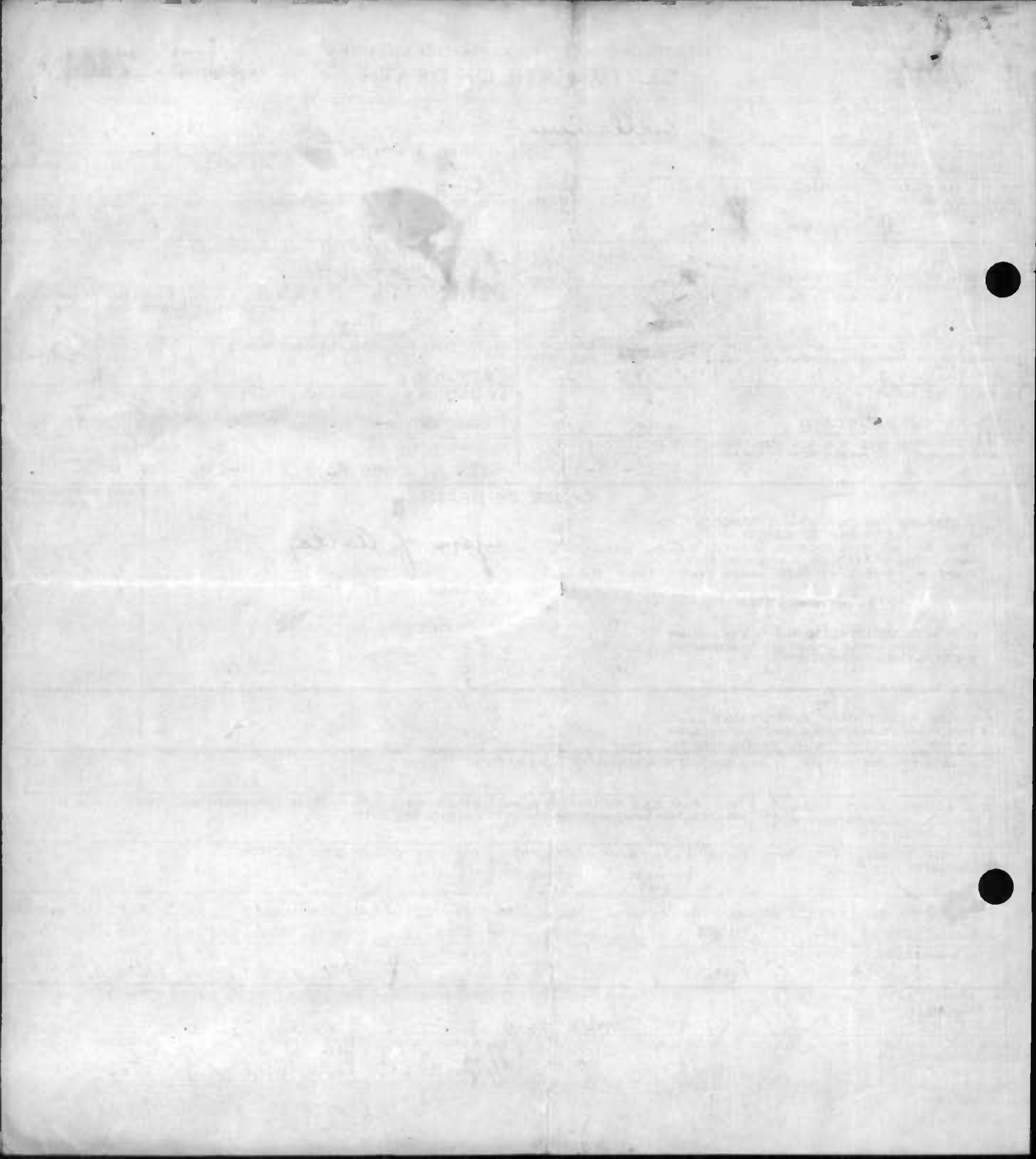
1. NAME OF DECEASED (Type or Print) <i>Sarah Elizabeth Mallalieu</i>		2. DATE OF DEATH <i>Aug. 19, 1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>1348 Pentwood Rd.</i>		C. CITY OR TOWN (If outside corporate limits, write R. ITAL and give township) <i>Baltimore</i>	
D. STREET ADDRESS (If rural, give location) <i>1348 Pentwood Rd.</i>		E. LENGTH OF stay in Baltimore Yrs. Mos. Days	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>Aug. 26, 1881</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	9. AGE (In years last birthday) <i>71</i>
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>John Henry Anderson</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>218-26-6009</i>	
17. INFORMANT <i>Mrs. Frances M. Fields</i>		ADDRESS <i>1348 Pentwood Rd.</i>	

18. <i>451X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Aneurysm of Aorta</i> (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO		
(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>8/21/53</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Aug 19, 1953</i> , to <i>Aug 19, 1953</i> , that I last saw the deceased alive on <i>Aug 19, 1953</i> , and that death occurred at <i>10A m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Jerome Gaber</i>		23B. ADDRESS <i>1104 E. Calaspring Lane</i>		23C. DATE SIGNED <i>Aug 19, 1953</i>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/21/53</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Pikesville, Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 20 1953</i>		REGISTRAR'S SIGNATURE <i>Harley H. ...</i>		25. FUNERAL DIRECTOR <i>Wm. J. ...</i>		ADDRESS <i>Balto. 17, Md.</i>	

MEDICAL CERTIFICATION



5-163

53 7445

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered 53 7445

1. NAME OF DECEASED (Type or Print) <b>BENJAMIN SHEPPARD</b>		2. DATE OF DEATH <b>8/19/53</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSP.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE</b>	
D. STREET ADDRESS (If rural, give location) <b>2211 LAKE AVENUE</b>		E. LENGTH OF STAY IN BALTIMORE <b>LIFE</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>	8. DATE OF BIRTH <b>3/29/1882</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MEAT DEALER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>	9. AGE (In years last birthday) <b>71</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BENJAMIN SHEPPARD</b>		14. MOTHER'S MAIDEN NAME <b>SARAH BURTON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>none</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Mrs. Amelia L. Sheppard</b>		ADDRESS <b>2211 E. Lake Ave.</b>	
18. <b>420.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarction</b> DUE TO <b>Coronary occlusion</b> DUE TO <b>Arteriosclerotic heart disease</b> DUE TO <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b> <b>1 mo.</b> <b>?</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7/16/53</b> , 19 <b>53</b> , to <b>8/19/53</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>8/19/53</b> , 19 <b>53</b> , and that death occurred at <b>3:40 P</b> m., from the causes and on the date stated above.			
23A. SIGNATURE <b>Henry S. Knock, Jr.</b>		23B. ADDRESS <b>Union Memorial Hosp.</b>	
23C. DATE SIGNED <b>8/19/53</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/19/53</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 20 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>	
VS 150		25. FUNERAL DIRECTOR <b>Wm. J. Lickner &amp; Sons</b> <b>2906A</b> <b>Balto. 17, Md.</b>	

MEDICAL CERTIFICATION

STATE OF NEW YORK  
 DEPARTMENT OF HEALTH  
 BUREAU OF VITAL STATISTICS  
 CERTIFICATE OF DEATH

FILE NO. 100-100000

100-100000

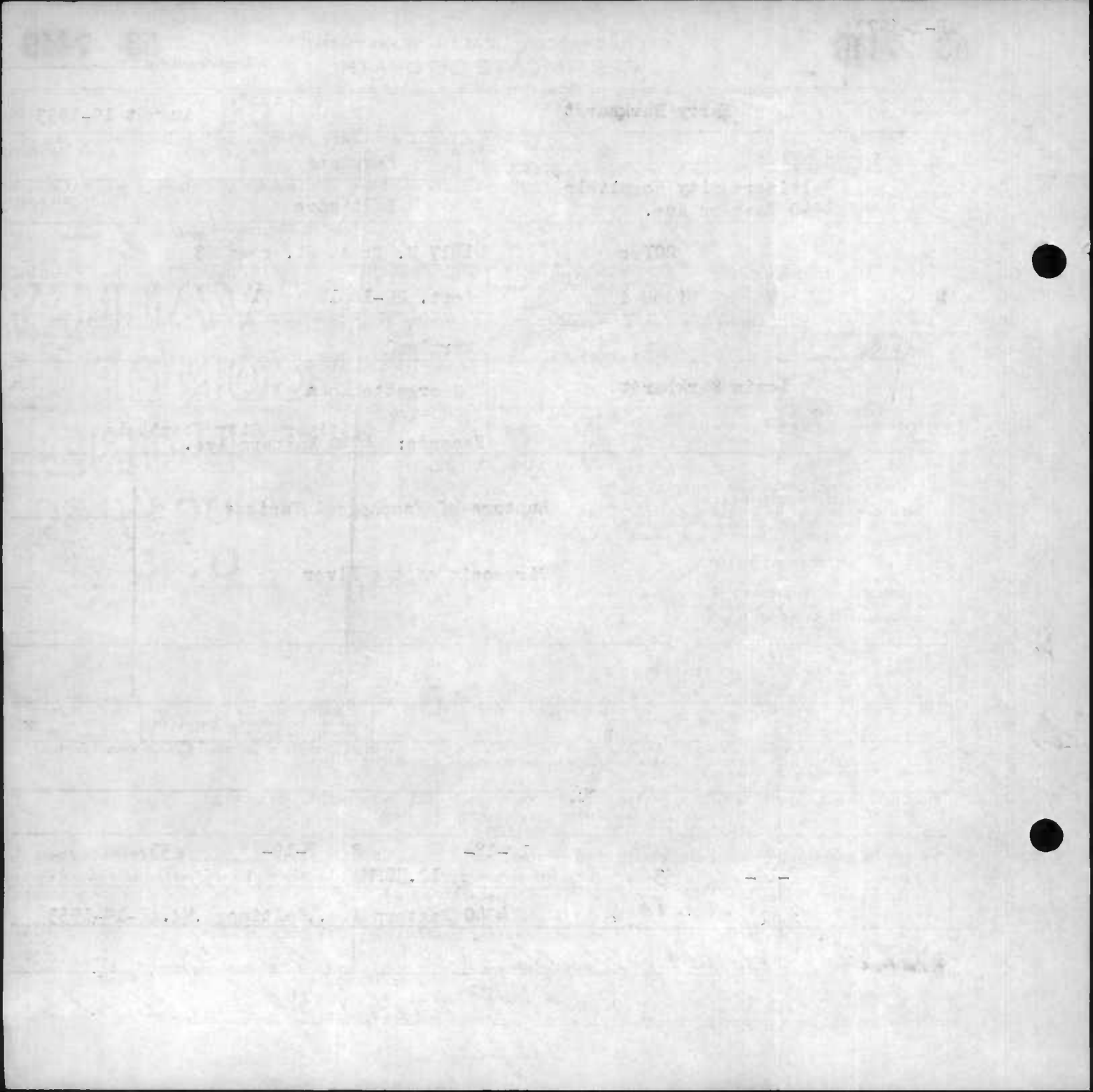
NAME OF DECEASED  
 SEX  
 AGE  
 DATE OF BIRTH  
 PLACE OF BIRTH  
 OCCUPATION  
 MARITAL STATUS  
 COLOR  
 RELIGION  
 EDUCATION  
 SERVICE IN ARMED FORCES  
 PLACE OF DEATH  
 DATE OF DEATH  
 TIME OF DEATH  
 CAUSE OF DEATH  
 MANNER OF DEATH  
 SIGNATURE OF PHYSICIAN  
 SIGNATURE OF REGISTRAR  
 SIGNATURE OF WITNESSES  
 SIGNATURE OF CORONER  
 SIGNATURE OF JURY  
 SIGNATURE OF JUDGE  
 SIGNATURE OF CLERK  
 SIGNATURE OF SHERIFF  
 SIGNATURE OF DEPUTY SHERIFF  
 SIGNATURE OF CONSTABLE  
 SIGNATURE OF ALDERMAN  
 SIGNATURE OF COUNCILMAN  
 SIGNATURE OF TOWN CLERK  
 SIGNATURE OF VILLAGE CLERK  
 SIGNATURE OF POST OFFICE CLERK  
 SIGNATURE OF SCHOOL CLERK  
 SIGNATURE OF CHURCH CLERK  
 SIGNATURE OF SYNAGOGUE CLERK  
 SIGNATURE OF MOSQUE CLERK  
 SIGNATURE OF TEMPLE CLERK  
 SIGNATURE OF CHAPEL CLERK  
 SIGNATURE OF CEMETERY CLERK  
 SIGNATURE OF BURIAL CLERK  
 SIGNATURE OF CREMATION CLERK  
 SIGNATURE OF INTERMENT CLERK  
 SIGNATURE OF REINTERMENT CLERK  
 SIGNATURE OF EXHUMATION CLERK  
 SIGNATURE OF TRANSFERRAL CLERK  
 SIGNATURE OF REINTERMENT CLERK  
 SIGNATURE OF EXHUMATION CLERK  
 SIGNATURE OF TRANSFERRAL CLERK

FILE NO. 100-100000



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-15977-26 53 7446		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 53 7446	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>Harry Burkhardt</b>			2. DATE OF DEATH <b>August 19-1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore <b>20Yrs</b>			D. STREET ADDRESS (If rural, give location) <b>1817 W. Pratt St. zone 23</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Sept. 29-1881</b>	9. AGE (in years last birthday) <b>71</b>	10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>		
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Louis Burkhardt</b>			14. MOTHER'S MAIDEN NAME <b>Georgette Kohn</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>-</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Baltimore City Hospitals</b> <b>Records: 4940 Eastern Ave.</b>	
18. <b>581.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Rupture of Esophageal Varices</b> DUE TO ANTECEDENT CAUSES <b>Cirrhosis of the Liver</b> DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>12-18</b> , 19 <b>52</b> , to <b>8-19</b> , 19 <b>53</b> that I last saw the deceased alive on <b>8-19</b> , 19 <b>53</b> , and that death occurred at <b>12.30PM.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>H. J. Burkhardt</b>		23B. ADDRESS <b>4940 Eastern Ave., Baltimore, Md.</b>		23C. DATE SIGNED <b>8-19-1953</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <b>8/21/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	
24D. LOCATION (City, town, or county) (State) <b>Woodlawn Md</b>					
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 20 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>		25. FUNERAL DIRECTOR ADDRESS <b>Paul E. Burkhardt 3615-11 Central Ave</b>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

E 212

53 7447

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 53 7447  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Anna D. Esposito

2. DATE  
OF  
DEATH

Aug. 18/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland 27 N. Clinton St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

27 N. Clinton St. Balto. Md.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

27 N. Clinton St.

C. CITY OR TOWN (If outside corporate limits, write R.R. and give township)  
Balto. Md.

c. Length of stay in Baltimore 40 yrs.

O. STREET ADDRESS (If rural, give location)  
27 N. Clinton St.5. SEX  
F.6. COLOR OR RACE  
W.7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Married.8. DATE OF BIRTH  
Dec. 15 18869. AGE (In years,  
last birthday)  
66 yrs.10. Under 1 Year  
Months: Days  
8 311. Under 24 Hours  
Hours: Min.  
10 1010A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
Housewife10B. KIND OF BUSINESS OR  
INDUSTRY  
Home11. BIRTHPLACE (State or foreign country)  
Portofino, Teramo Italy12. CITIZEN OF  
WHAT COUNTRY?  
Italy

13. FATHER'S NAME

Nicolo Atterrese

14. MOTHER'S MAIDEN NAME

Francesca Di Gennaro

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

no

16. SOCIAL  
SECURITY NO.17. INFORMANT 27 N. Clinton St.  
Mr. Alphonso Esposito
 18. 443X and 260X  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

 CAUSE OF DEATH  
(A) Hypertensive Cardiovascular Disease  
DUE TO
INTERVAL BETWEEN  
ONSET AND DEATH

## ANTECEDENT CAUSES

 DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

 (B) Hypertension  
DUE TO

## II

 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONITION CAUSING IT.

Diabetes Mellitus

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED19C. IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ WORK NOT WHILE ☐  
AT WORK

21F. HOW DID INJURY OCCUR?

 22. I hereby certify that I attended the deceased from Jan. 5, 1952, to August 18, 1953, that I last saw the  
deceased alive on 8-17, 1953, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

John Costantini

23B. ADDRESS

234 S. Conbling St.

23C. DATE SIGNED

8-19-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 21/53

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county)

Belair Rd. &amp; Moravia

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

AUG 20 1953

REGISTRAR'S SIGNATURE

Thurtington Williams

25. FUNERAL DIRECTOR

Frank Della Noce 322 S. High St.

ADDRESS

 Frank Della Noce  
322 S. High St.

1947 52

1947 52

James C. [unclear]

53 R-262  
7448BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7448

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES ROGERS

2. DATE  
OF  
DEATH

August 18, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Provident Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Balto.

D. STREET ADDRESS (If rural, give location)

1831 Lorman St.

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

7/22/45

9. AGE (In years  
last birthday)

8

10. Under 1 Year  
Months Days11. Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Jesse Rogers

14. MOTHER'S MAIDEN NAME

Mozella Overton

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS

Jesse Rogers 1831 Lorman St.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DROWNING

DUE TO

ANTECEDENT CAUSES

(B)

PULMONARY EDEMA

DUE TO

(C)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

in ditch

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Presstman + Bentallow

15/3

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

Aug. 18, 1953 12:15 p.m.

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

fell in ditch partly filled with water

22. I certify that I took charge of the remains described above, held an  
Autopsy, Inspection or Inquiry thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Joseph A. Jachin

M.D.

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

8-18-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8/22/53

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

1303 Presstman St.

Geo. G. Nelson

Geo. G. Nelson

VS 151

N-990x

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-230  
53 7449

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7449

BIRTH NO.			1. NAME OF DECEASED (Type or Print) <b>WILLIAM BECKETT</b>			2. DATE OF DEATH <b>August 18, 1953</b>		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Md.</b> b. COUNTY			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto.</b>		
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital</b>			d. STREET ADDRESS (If rural, give location) <b>1849 Lorman St.</b>			15-02		
c. Length of stay in Baltimore <b>Life</b>	Yrs. <b>Life</b>	Mos. <b>Life</b>	5. SEX <b>M</b>			6. COLOR OR RACE <b>C</b>		
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)			8. DATE OF BIRTH <b>7/24/46</b>			9. AGE (In years last birthday) <b>7</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		
13. FATHER'S NAME <b>Samuel Beckett</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Randall</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Margaret Beckett 1849 Lorman St.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			ADDRESS					

18. <b>929.5</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>DROWNING</b>			
DUE TO					
ANTECEDENT CAUSES		(B) <b>PULMONARY EDEMA</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>in ditch</b>		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Presstman &amp; Bentlows Sts 15-03</b>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>Aug. 18, 1953 10:15 AM</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>while playing</b>	
22. I certify that I took charge of the remains described above, held an <b>AUTOPSY</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23a. SIGNATURE <b>Joseph A. Jachimczyk</b>		23b. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23c. DATE SIGNED <b>8-18-53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>8/22/53</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary</b>	
24d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		24e. FUNERAL DIRECTOR <b>Geo. S. Nelson 1303 Presstman St.</b>		24f. ADDRESS <b>Geo. S. Nelson</b>	

1915

OFFICE OF THE SECRETARY OF THE ARMY

1915

5

5-345

53 7450  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7450

1. NAME OF DECEASED (Type or Print) <b>FLORENCE A. STALLINGS</b>			2. DATE OF DEATH <b>Aug 19, 1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>25-51</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>5135 FREDERICK AVE.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE</b>		
D. Length of stay in Baltimore <b>LIFE</b>			E. STREET ADDRESS (If rural, give location) <b>5135 FREDERICK AVE.</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>JUNE 27, 1875</b>		9. AGE (In years last birthday) <b>78</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>WILLIAM D. MARIS</b>			14. MOTHER'S MAIDEN NAME <b>MARY FISHER</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.			
17. INFORMANT			ADDRESS <b>HOWARD G. BRAECKLEIN 5135 FREDERICK AVE.</b>		

18. <b>585X</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) <b>Cardiac failure</b>	<b>24 hours</b>	
ANTECEDENT CAUSES		(B) <b>Cholecystitis</b>	<b>5 days</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				

19A. DATE OF OPERATION <b>01</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>Aug 14</b> , 1953, to <b>Aug 18</b> , 1953, that I last saw the deceased alive on <b>Aug 18</b> , 1953, and that death occurred at <b>1:30 a.m.</b> , from the causes and on the date stated above.				
23A. SIGNATURE <b>Edward G. Yaffe</b>		23B. ADDRESS <b>3101 W. Baltimore St.</b>		23C. DATE SIGNED <b>8/19/53</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>Aug 22, 1953</b>	24C. NAME OF CEMETERY OR CREMATORY <b>LONDON PARK</b>	24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 20 1953</b>	REGISTRAR'S SIGNATURE <b>William J. Hall</b>	25. FUNERAL DIRECTOR <b>Joseph J. Linton 1325 E. Charles St.</b>		

MEDICAL CERTIFICATION









M-620  
53 7452

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

X Registered No. 53 7452

1. NAME OF DECEASED (Type or Print) <b>MRS. CYLENA MORRIS</b>		2. DATE OF DEATH <b>August 20, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Church Home &amp; Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Honfords</b>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME AND HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Doulington R.F.D. 2</b>	
Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>6200</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>July 15, 1887</b>
9. AGE (in years last birthday) <b>66</b>		10. Under 1 Year Months: Days	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>House wife</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Howard Jones</b>		14. MOTHER'S MAIDEN NAME <b>Olivia Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Cylena Morris</b>		ADDRESS	
18. <b>422.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Anteroseleoron's + Myocardial Degeneration</b> DUE TO <b>Anteroseleoron's + Myocardial Degeneration</b> DUE TO <b>Anteroseleoron's + Myocardial Degeneration</b> DUE TO <b>Anteroseleoron's + Myocardial Degeneration</b>			INTERVAL BETWEEN ONSET AND DEATH
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Anteroseleoron's + Myocardial Degeneration</b> DUE TO <b>Anteroseleoron's + Myocardial Degeneration</b> DUE TO <b>Anteroseleoron's + Myocardial Degeneration</b> DUE TO <b>Anteroseleoron's + Myocardial Degeneration</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>August 3, 1953</b>		19B. MAJOR FINDINGS OF OPERATION <b>Gangrene of the left leg.</b>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>July 25</b> , 19 <b>53</b> , to <b>August 20</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>August 20</b> , 19 <b>53</b> , and that death occurred at <b>9:35 a.m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Reed Carroll</b>		23B. ADDRESS <b>Church Home &amp; Hospital</b>	
23C. DATE SIGNED <b>8/20/53</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>August 22, 1953</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Harford Co Md</b>		24D. LOCATION (City, town, or county) (State) <b>Harford Co Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 20 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington</b>	
25. FUNERAL DIRECTOR <b>VS 150</b>		ADDRESS <b>Harford Co Md</b>	

MEDICAL CERTIFICATION

SECRET

CONFIDENTIAL

SECRET

CONFIDENTIAL

R-000

53 7453

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7453

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

E. GRACE RAY

2. DATE  
OF  
DEATH

Aug. 19, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

5146 Stafford Rd.

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

5146 Stafford Rd.

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Widowed

8. DATE OF BIRTH

March 19, 1876

9. AGE (in years  
last birthday)

77

10. Under 1 Year 11. Under 24 Hours  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
Housewife10B. KIND OF BUSINESS OR  
INDUSTRY  
at home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Lemuel German

14. MOTHER'S MAIDEN NAME

Eunice Pierce

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)  
no16. SOCIAL  
SECURITY NO.  
no

17. INFORMANT

ADDRESS

Mrs. David S. Phillips-5146 Stafford Rd.

18. 422.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

Arteriosclerotic  
Degenerative Cardio-  
vascular diseaseINTERVAL BETWEEN  
ONSET AND DEATH

5 years

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

None

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

m.

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-3, 1952 to 8-19, 1953, that I last saw the  
deceased alive on 8-15, 1953, and that death occurred at 8 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial  
DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

CERTIFICATE OF DEATH

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>		<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>		<p>5. Time of death: _____</p>		<p>6. Place of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Manner of death: _____</p>		<p>9. Signature of physician: _____</p>	
<p>10. Signature of registrar: _____</p>		<p>11. Signature of informant: _____</p>		<p>12. Signature of witness: _____</p>	



21



53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

E 152

7455

BIRTH NO.

# EVANS BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

53

7455  
7455

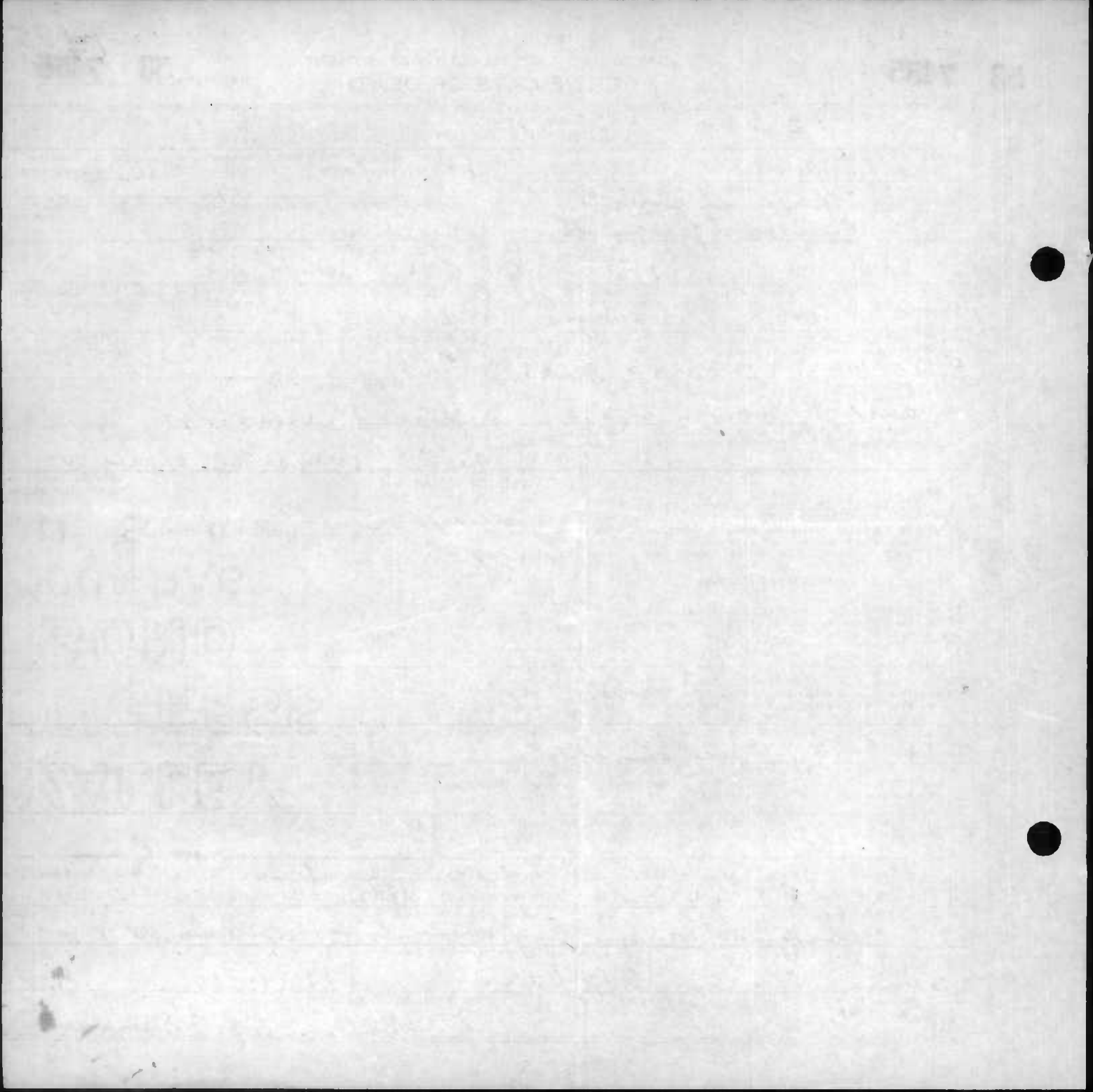
1. NAME OF DECEASED (Type or Print) <i>Daniel Evans, Jr.</i>			2. DATE OF DEATH <i>8-20-53</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital Redwood &amp; Greene Sts.</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>		
C. Length of stay in Baltimore <i>LIFE</i>			D. STREET ADDRESS (If rural, give location) <i>6627 Bushey Ave.</i>		
5. SEX <i>male</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>JULY 13, 1917</i>		9. AGE (in years last birthday) <i>36</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>POLICEMAN, SPARKS POINT</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Daniel P. Evans, Sr.</i>			14. MOTHER'S MAIDEN NAME <i>Anna M. Deuchler</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Lucille E. Evans</i>		
			ADDRESS <i>6627 Bushey St.</i>		

18. <i>159X</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Carcinomatosis (G.I. Tract origin?)</i>		
ANTECEDENT CAUSES		(B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO		
		(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				

19A. DATE OF OPERATION <i>4-8-53</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Abd. pain, cholelithiasis</i>	IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *8-11-53*, 19\_\_, to *8-20-53*, 19\_\_, that I last saw the deceased alive on *8-19*, 19*53*, and that death occurred at *3:45 Am.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Sadashin Masani</i>	M. D.	23B. ADDRESS <i>University Hosp., Baltimore, Md.</i>	23C. DATE SIGNED <i>8-20-53</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>8/24/53</i>	24C. NAME OF CEMETERY OR CREMATORY <i>OAKLAWN</i>	24D. LOCATION (City, town, or county) (State) <i>BALTO. CO. MD.</i>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR <i>P.T. Hoffmann</i>	ADDRESS <i>16399 Broadway</i>



53 7486

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

53

7456  
7486

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Joseph Schultz

2. DATE  
OF  
DEATH

8/20/53

3. PLACE OF DEATH:

Baltimore City, Maryland ~~GERMANY~~

4. USUAL RESIDENCE (Where deceased lived. If institution; residence

A. STATE

B. COUNTY

before admission)

5. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Lutheran Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Pittsburgh PA.

6. STREET ADDRESS (If rural, give location)

(619 Stuart St) 515 E.

Diamond St

Length of stay in Baltimore

5 DAYS.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

8/13/1903

9. AGE (In years

last birthday)

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

50

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Truck Driver

10B. KIND OF BUSINESS OR  
INDUSTRY

Fort Pitt Tomato Co.

11. BIRTHPLACE (State or foreign country)

GERMANY

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr Joseph A Schultz Jr.

515 E. Diamond St

18. 331X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Cerebral vascular accident.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Arteriosclerosis

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK22. I hereby certify that I attended the deceased from 8/19/53, 19\_\_, to 8/20, 1953, that I last saw the  
deceased alive on 8/20, 1953, and that death occurred at 7:45 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Ford

M. D.

23B. ADDRESS

Lutheran Hospital.

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

8/24/53

Pittsburgh PA.

Pittsburgh.

PA

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

PASSAVER Funeral Home 7401 Bel Air Rd.

BALTO. 6. MD.

AUG 20 1953

VS 150

6 F 3 6 3

MEDICAL CERTIFICATION



2-560  
53 7457BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

7457  
53 7457

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Robert H. Comer

2. DATE  
OF  
DEATH

Aug. 20, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived, or institution: residence

A. STATE

Maryland

B. COUNTY

Frederick

(before admission)

C. CITY OR TOWN

Frederick

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

314 E Third St.

6011

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Feb. 20, 1936

9. AGE (in years  
last birthday)

17

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Walter R. Comer

14. MOTHER'S MAIDEN NAME

Mellie H. Holtz

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war and dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Walter Comer

ADDRESS

314 E Third St. Frederick

18. 590X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Subacute nephritis E

2 mos.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Anemia

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from Aug. 15, 1953, to Aug. 20, 1953, that I last saw the  
deceased alive on Aug. 20, 1953, and that death occurred at 1:56 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Valeriana B. Castillo

M. O.

23B. ADDRESS

Maryland General Hospital

23C. DATE SIGNED

8/20/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

8/24/53

24C. NAME OF CEMETERY OR CREMATORY

Mt. Olivet

24D. LOCATION (City, town, or county)

Frederick, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

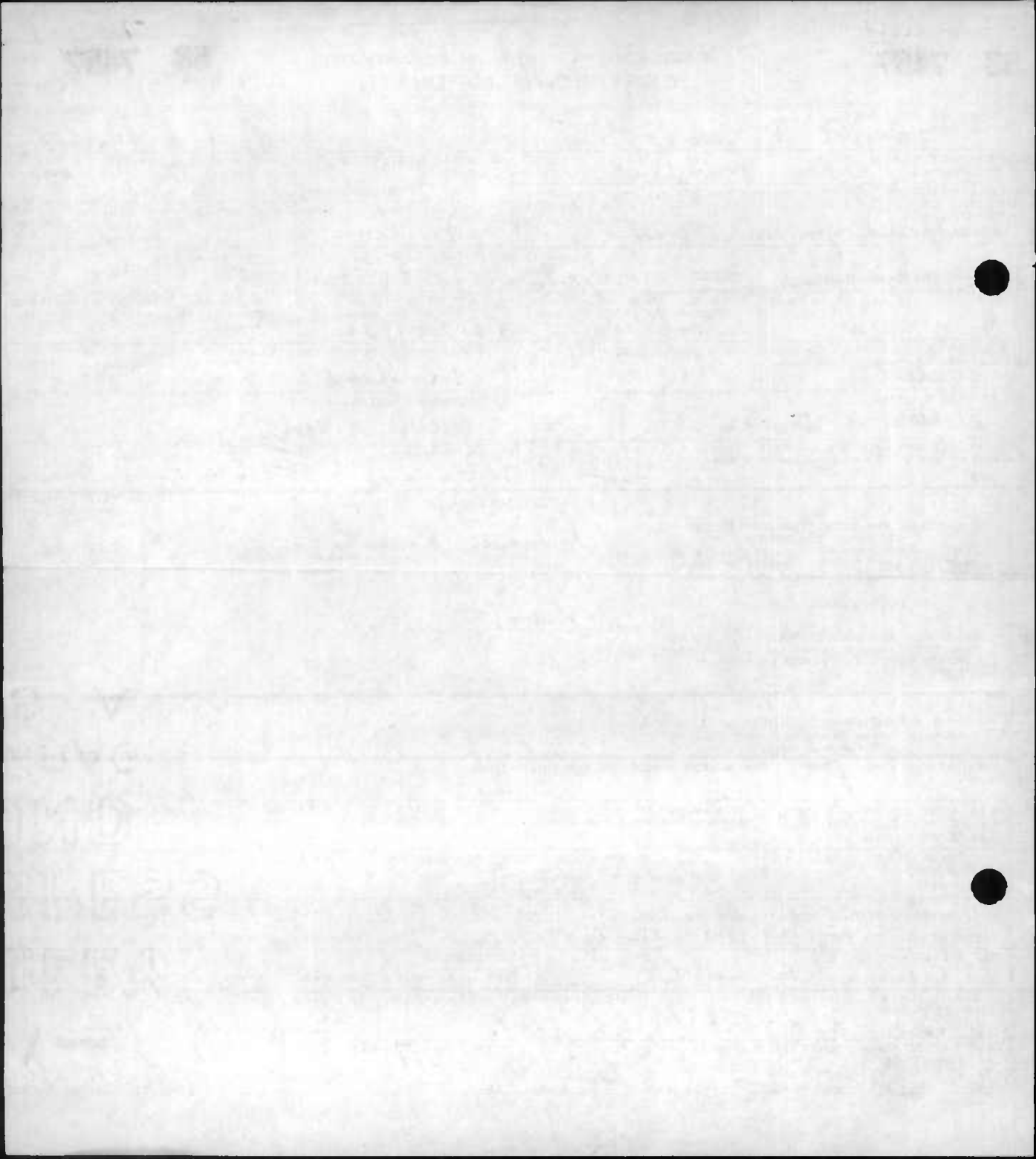
REGISTRAR'S SIGNATURE

Huntington W. Harrison, M.D.

25. FUNERAL DIRECTOR

W. P. Elchison, Jr. - Frederick, Md.

ADDRESS





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-121238 B-620

53 7458

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 53 7458  
7458

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Rose Berg

2. DATE  
OF  
DEATH

August 19-1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE Maryland

B. COUNTY before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTE Baltimore City Hospitals

4940 Eastern Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

502 N. Collington Ave. zone 5

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

June 11-1889

9. AGE (In years

last birthday)

64

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Albert Foster

14. MOTHER'S MAIDEN NAME

Lilly Stemmer (Stemmer)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT 4940 Eastern Ave. ADDRESS

Records: Baltimore City Hospitals

18. 203x

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho Pneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B) Multiple Myeloma

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ WORKNOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-15-1953, to 8-19-1953, that I last saw the deceased alive on 8-19-1953, and that death occurred at 1.05 PM, from the causes and on the date stated above.

23A. SIGNATURE

H. E. S. E. V. S. I. O. A.

M. D.

23B. ADDRESS

4940 Eastern Ave., Baltimore, Md.

23C. DATE SIGNED

8-19-1953

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-22-53

24C. NAME OF CEMETERY OR CREMATORY

Trinity

24D. LOCATION (City, town, or county)

Baltimore - Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

10-11-70

10-11-70

10-11-70

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10-11-70

10-11-70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-200 53 7459		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		53 7459 Registered No.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>LOUIS WISE</i>		2. DATE OF DEATH <i>8/20/53</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>15-12</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>SINAI</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>			
D. STREET ADDRESS (If rural, give location) <i>3627 Reisterstown Rd</i>					
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	
8. LENGTH OF STAY IN BALTIMORE <i>42</i> Yrs. <i>50</i> Mos. <i>Days</i>		9. AGE (In years last birthday) <i>78</i>		10. UNDER 1 Year Months: Days Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Jewelry</i>		11. BIRTHPLACE (State or foreign country) <i>Hungary</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Not Known</i>		14. MOTHER'S M maiden name <i>Not Known</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Ester Katzew-</i>	
18. <i>331X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral Vascular Accident</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		19C. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>7/30</i> , 19 <i>53</i> , to <i>8/20</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>8/20/53</i> , 19 <i>53</i> , and that death occurred at <i>6:20 A.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Robert S. Coplan</i>		23B. ADDRESS <i>Sinai Hospital</i>		23C. DATE SIGNED <i>8/20/53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-21-53</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore Hebrew</i>	
24D. LOCATION (City, town, or county) <i>Balto Md</i>		24E. DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 21 1953</i>		24F. REGISTRAR'S SIGNATURE <i>Harry W. Williams</i>	
24G. FUNERAL DIRECTOR <i>Jack Reigis Inc</i>		24H. ADDRESS <i>2100 Eutan Rd</i>			

53 7450

53

53 7450

STATE OF TEXAS

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "STATE OF TEXAS" and "COUNTY OF" are faintly visible.]*

M-600

CCG-173571

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 53 7460

BIRTH No. <b>53 7460 51-01406</b>		1. NAME OF DECEASED (Type or Print) <b>Walter Allen Murray Jr.</b>		2. DATE OF DEATH <b>Aug. 19, 1953</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern, Ave</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>			
c. Length of stay in Baltimore <b>Life</b>		O. STREET ADDRESS (If rural, give location) <b>1502 Eutaw Place #17</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>		8. DATE OF BIRTH <b>Jan. 21, 1951</b>	9. AGE (In years last birthday) <b>2 1/2</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Walter Allen Murray, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Blanche Lester</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>B. C. H. 4940 n Eastern, Ave.,</b>	

18. <b>E 885.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Encephalitis</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) <b>Encephalitis</b> DUE TO			
		(B) <b>Atelectasis Lower Lobe of both Lungs</b> DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) <b>CERTIFICATION APPROVED BY</b> <i>Joseph A. Jackson</i> M. D. CHIEF OR ASST. MEDICAL EXAMINER.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1502 Eutaw Place</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>in August</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>chewing on paint</b>	
22. I hereby certify that I attended the deceased from <b>8-18</b> , 19 <b>53</b> , to <b>8-19</b> , 19 <b>53</b> that I last saw the deceased alive on <b>8-19</b> , 19 <b>53</b> , and that death occurred at <b>5:20p</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Walter Allen Murray Jr.</i>		23B. ADDRESS <b>4940 Eastern, Ave, Balto, Md</b>		23C. DATE SIGNED <b>8-19-53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-21-53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 21 1953</b>		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>		24D. LOCATION (City, town, or county) <b>Balto Md</b>	
VS 150		25. FUNERAL DIRECTOR <i>Walter Allen Murray Jr.</i>		ADDRESS <b>2100 Eutaw Pl</b>	
To be approved by Medical Examiners					

N 966.0



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully analyzed. The correct age is especially important. Physicians: Please write causes of death clearly and legibly.

MEDICAL CERTIFICATION

LOCAL REGISTRAR  
DATE RECEIVED BY  
REGISTRAR'S SIGNATURE

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

25. FUNERAL DIRECTOR  
ADDRESS

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_, from the causes and on the date stated above.

21. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)  
21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office, highway, etc.)  
21C. HOW OLD INJURY OCCURRED  
21D. HOW OLD INJURY OCCURRED

19A. DATE OF OPERATION  
WAS PERFORMED  
19B. CONDITION FOR WHICH OPERATION  
IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II  
20. AUTOPSY?  
YES ☐ NO ☐

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT

18. CAUSE OF DEATH  
INTERVAL BETWEEN  
ONSET AND DEATH  
ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.  
DUE TO  
(C)  
(B)  
(A) DUE TO  
INJURY OR COMPLICATION WHICH CAUSED DEATH.  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)  
DUE TO  
(A)  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

17. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(If yes, give war in dates of service)  
18. SECURITY NO.  
19. SOCIAL  
17. INFORMANT  
ADDRESS

13. FATHER'S NAME  
14. MOTHER'S MAIDEN NAME

10A. USUAL OCCUPATION (Give kind of  
work done during course of working life, even if retired)  
10B. KIND OF BUSINESS OR  
INDUSTRY  
11. BIRTHPLACE (State or foreign country)  
12. CITIZEN OF  
WHAT COUNTRY?

9. AGE (in years)  
last birthday Months Days Hours Min.  
10. LENGTH OF STAY IN BALTIMORE  
Yrs. Mos. Days

6. FULL NAME OF  
HOSPITAL OR  
INSTITUTION  
(If not in hospital or institution, give street address of  
location)  
7. PLACE OF DEATH:  
a. Baltimore City, Maryland  
b. BALTIMORE CITY, MARYLAND

3. PLACE OF DEATH:  
a. BALTIMORE CITY, MARYLAND  
b. BALTIMORE CITY, MARYLAND  
c. CITY OR TOWN  
(If outside corporate limits, write RURAL and give  
township)  
d. STREET ADDRESS (If rural, give location)  
e. STATE  
f. COUNTY  
g. USUAL RESIDENCE (Where deceased lived, if institution: residence  
before admission)  
h. DATE  
i. OF  
DEATH

CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

Registered No.



53 7461

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7461

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH W. BOWEN, Jr.

2. DATE  
OF  
DEATH

Aug. 20, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

University Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

119 W. Mosher Street

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

April 28, 1913

9. AGE (In years  
last birthday)

40

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Crane Operator

10B. KIND OF BUSINESS OR  
INDUSTRY

Maryland Dry Dock Co.

11. BIRTHPLACE (State or foreign country)

Solomons Island, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Joseph W. Bowen, Sr.

14. MOTHER'S MAIDEN NAME

Pearl Bowen

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

W. W. II

16. SOCIAL  
SECURITY NO.

212-07-2561

17. INFORMANT

ADDRESS

Erma Bowen, 119 W. Mosher Street

18. E 902.3 I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, assthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Crashing injury of chest

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Fracture of right femur

DUE TO Rupture of left leaf of diaphragm

(C) Multiple skin laceration and abrasions

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

at work

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Md. Dry Dock Co., Fairfield, Md.

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

Aug. 20, 1953

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

was a pile of refrigeration coils fallen  
on him22. I certify that I took charge of the remains described above, held an  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Joseph P. Jachimczyk

M.D.

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

8/20/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

8/24/53

24C. NAME OF CEMETERY OR CREMATORY

Mt. Olivet Cemetery

24D. LOCATION (City, town, or county)

Baltimore,

Maryland

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 21 1953

H. H. Williams

Wm. Cook &amp; Co.

1217 St. Paul Street

VS 151

N 862.2

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53 7463

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7463

1. NAME OF DECEASED (Type or Print) <b>NELLIE T. RAFFERTY</b>			2. DATE OF DEATH <b>Aug. 19, 1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>3801 ELLERSLIE AVE</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 9-01</b>		
D. STREET ADDRESS (If rural, give location) <b>3801 ELLERSLIE AVE</b>					
5. SEX <b>FEMALE</b>			6. COLOR OR RACE <b>WHITE</b>		
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>			8. DATE OF BIRTH <b>JAN. 24, 1893</b>		
9. AGE (In years last birthday) <b>60</b>			10. Under 1 Year Months Days		
11. Under 24 Hours Hours Min.			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME <b>Joseph O'BRIEN</b>			14. MOTHER'S MAIDEN NAME <b>MARY ELLEN HOPPER</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		
17. INFORMANT <b>HUSBAND-DAVID W. RAFFERTY</b>			ADDRESS <b>3801 ELLERSLIE AVE</b>		

18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) <b>Carotid thrombosis</b>		DUE TO		<b>Sudden</b>	
(B) <b>Myocardial decompensation 4 mos.</b>		DUE TO			
(C) .....					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

**Partial carotid thrombosis 1948.**

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **4/13** 19**53** to **Aug. 19**, 19**53** that I last saw the deceased alive on **8/18**, 19**53** and that death occurred at **1 A.** m., from the causes and on the date stated above.

23A. SIGNATURE <b>J. William Gaytan</b>		23B. ADDRESS <b>3961 Greinmann Ave</b>		23C. DATE SIGNED <b>8/21/53</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>Aug. 22, 1953</b>		24C. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL CEM.</b>	
24D. LOCATION (City, town, or county) (State) <b>FREDERICK RD. BALTI., MD.</b>		24E. FUNERAL DIRECTOR <b>JOHN A. MORAN</b>		24F. ADDRESS <b>3000 E. BALTIMORE ST.</b>	

DATE RECEIVED BY  
LOCAL REGISTRAR  
**AUG 21 1953**

REGISTRAR'S SIGNATURE

**Huntington Williams**

25. FUNERAL DIRECTOR

**JOHN A. MORAN, 3000 E. BALTIMORE ST.  
BALTIMORE, MD.**

3961



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-424

53 7464

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7464

1. NAME OF DECEASED (Type or Print) <b>JOHN FRANK MILCHLING</b>		2. DATE OF DEATH <b>8/19/53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTO-INC</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 6-02</b>	
D. STREET ADDRESS (If rural, give location) <b>110 N. PORT ST. #24</b>			
5. LENGTH OF STAY IN BALTIMORE <b>42</b>	6. LIFE		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Holy Redeemer Cem.</b>	10B. KIND OF BUSINESS OR INDUSTRY <b>GRAVE Digger</b>	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, M.D.</b>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>FRANK MILCHLING</b>	14. MOTHER'S MAIDEN NAME <b>MARY Vogel</b>	17. INFORMANT <b>Brother John H. Milchling</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>?</b>	16. SOCIAL SECURITY NO. <b>218-01-6286</b>	ADDRESS <b>110 N. PORT ST BALTO MD</b>	
18. <b>151X</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>BILE PERITONITIS</b>	
ANTECEDENT CAUSES		(B) <b>BILE DUCT OPERATIVE INJURY 15 days</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) <b>CARCINOMA OF STOMACH WITH INVASION OF ESOPHAGUS 6 MOS</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>RIGHT LOWER LOBE PNEUMONIA 5 days</b>	
19A. DATE OF OPERATION <b>8/13/53</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CARCINOMA OF STOMACH BILE PERITONITIS</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>8/14/53</b> , 19 <b>53</b> , to <b>8/19</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>8/19</b> , 19 <b>53</b> , and that death occurred at <b>10:00</b> m., from the causes and on the date stated above.			
23A. SIGNATURE <b>Howard N Rosenthal</b>		23B. ADDRESS <b>1031 N. Broadway</b>	23C. DATE SIGNED <b>8/19/53</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>Aug 24, 1953</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Belair Road, Baltimore Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 21 1953</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams</b>	25. FUNERAL DIRECTOR <b>JOHN A. MORAN, 3000 E. Baltimore ST</b>	
		ADDRESS <b>BALTIMORE, MD.</b>	

97074



G-651

53 7465

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7465

1. NAME OF DECEASED (Type or Print) <b>PAUL GREEN BLATT</b>		2. DATE OF DEATH <b>8-20-53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>15-37</b>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>3308 Bateman Ave</b>		C. CITY OR TOWN <b>Baltimore</b>	
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <b>3308 Bateman Ave</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>4-1</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Liquor</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>
13. FATHER'S NAME <b>Harry</b>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Shirley Greenblatt - Sane</b>		ADDRESS	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction 2 days</b> DUE TO (A) <b>Coronary Thrombosis</b> DUE TO (B) <b>?</b> DUE TO (C) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>8-20 1953</b> , to <b>8-20</b> , 1953, that I last saw the deceased alive on <b>8-20</b> , 1953, and that death occurred at <b>8-20</b> m., from the causes and on the date stated above.			
23A. SIGNATURE <b>Stanley R. Steinbach</b>		23B. ADDRESS <b>3334 Dolfield Ave</b>	
23C. DATE SIGNED <b>8-21-53</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-21-53</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Beth Telson</b>		24D. LOCATION (City, town, or county) (State) <b>Balto, Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 21 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Halliwell</b>	
VS 150		FUNERAL DIRECTOR <b>Jack Brown</b> ADDRESS <b>2100 Eutan Pl</b>	
		<b>49068</b>	

MEDICAL CERTIFICATION

Stembach  
3334 Doelfield Ave  
h2 4546  
8918

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N-151

53 7466

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7466

Registered No.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
GEORGE JOSEPH NOPPENBERGER		8/19/53	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 621 Springfield Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 621 Springfield Avenue	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 1885
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packing clerk		10B. KIND OF BUSINESS OR INDUSTRY F.X. Ganter Co	9. AGE (In years last birthday) 70
11. BIRTHPLACE (State or foreign country) Balto. Co.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jas. C. Noppenberger		14. MOTHER'S MAIDEN NAME Mary A. McGee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS Miss Loretta Noppenberger	

18. 161X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) <i>Broncho pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH 10 days 2 yrs.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) <i>Carcinoma of larynx</i>		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8/14, 1953, to 8/19, 1953 that I last saw the deceased alive on 19, and that death occurred at 10 <sup>30</sup> p. m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Anthony J. Shuman</i>		23B. ADDRESS 4600 York Rd		23C. DATE SIGNED 8/21/53	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/22/53		24C. NAME OF CEMETERY OR CREMATORY St. Josephs	
24D. LOCATION (City, town, or county) Balto. Co.		25. FUNERAL DIRECTOR <i>Wiedefeld &amp; Son</i> GREENMOUNT AVE & 22ND			
DATE RECEIVED BY LOCAL REGISTRAR AUG 21 1953		REGISTRAR'S SIGNATURE <i>Wiedefeld &amp; Son</i>		ADDRESS	

VS 150

690.99

MEDICAL CERTIFICATION

23 7106

RECEIVED BY THE BUREAU OF THE ARMY

DEPARTMENT OF THE ARMY

13 7106

13 7106

13





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7467

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7467  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Amelia Rose Van Reuth</i>		2. DATE OF DEATH <i>August 20, 1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>5230 Harford Rd.</i>		C. CITY OR TOWN (If outside corporate limits, write full name and give township) <i>Baltimore</i>	
D. LENGTH OF STAY IN BALTIMORE <i>00</i> Yrs. <i>00</i> Mos. <i>00</i> Days		D. STREET ADDRESS (If rural, give location) <i>5230 Harford Road</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>July 26, 1874</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>AT Home</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>79</i>
11. BIRTHPLACE (State or foreign country) <i>Switzerland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>VITAL ARAND</i>		14. MOTHER'S MAIDEN NAME <i>Rosa HANDLOSER</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>MR Edward VAN Reuth - Echodale</i>		ADDRESS <i>3107</i>	

18. <i>420.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Acute Coronary Occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Arteriosclerotic Heart Disease</i>		<i>5 yrs.</i>
DUE TO		
(C)		

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION <i>0</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *0001* 19*43*, to *Aug 20*, 1953, that I last saw the deceased alive on *Aug 16*, 1953, and that death occurred at *12:30 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE <i>George Sawyer</i>	23B. ADDRESS <i>4808 Harford Rd.</i>	23C. DATE SIGNED <i>8/20/53</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>8-22-53</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cem.</i>
24D. LOCATION (City, town, or county) <i>BALTO Md</i>	24E. STATE <i>Md</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 21 1953</i>	REGISTRAR'S SIGNATURE <i>H. E. ...</i>	25. FUNERAL DIRECTOR'S ADDRESS <i>Leonard J. Ruck 5305 Harford</i>

1987 10

1987 10

1987 10

J-520  
53 7468BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7468  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MR. WILLIAM ALBERT JONES

2. DATE  
OF  
DEATH

8/20/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

UNION MEMORIAL HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admision)  
A. STATE

MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
BALTIMORE-18

D. STREET ADDRESS (If rural, give location)

1521 SHADYSIDE ROAD

Length of stay in Baltimore

LIFE

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

10/3/1893

9. AGE (In years  
last birthday)

59

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

MARINE ENGINEER

10B. KIND OF BUSINESS OR  
INDUSTRY

ARUNDEL CORP

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

URIAH JONES

14. MOTHER'S MAIDEN NAME

ELIZABETH DONOHUE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown)

?

(If yes, give war or dates of service)

-

16. SOCIAL  
SECURITY NO.

219-12-5991

17. INFORMANT

ADDRESS

WIFE - Caroline K. SAME

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Cerebral vascular accident

24 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Hypertensive cardiovascular  
disease

6-7 yrs.

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/19/1953 to 8/20/1953 that I last saw the  
deceased alive on 8/20/1953 and that death occurred at 3:50 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Henry S. Knock, Jr.

M. D.

23B. ADDRESS

Union Memorial Hosp.

23C. DATE SIGNED

8/20/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

Aug 24-1953

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Donald J. Ruck

ADDRESS

5305 Harford

VS 150

240 55

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

February 1, 1911

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the proper authorities.

I am, Sir, very respectfully,  
Yours truly,  
J. B. H. [Signature]

Very truly yours,  
J. B. H. [Signature]

Enclosed for you are two copies of the report of the [Name] [Title] [Department] [City] [State] [Country] [Date]

and one copy of the report of the [Name] [Title] [Department] [City] [State] [Country] [Date]

and one copy of the report of the [Name] [Title] [Department] [City] [State] [Country] [Date]

and one copy of the report of the [Name] [Title] [Department] [City] [State] [Country] [Date]

and one copy of the report of the [Name] [Title] [Department] [City] [State] [Country] [Date]

and one copy of the report of the [Name] [Title] [Department] [City] [State] [Country] [Date]

and one copy of the report of the [Name] [Title] [Department] [City] [State] [Country] [Date]

and one copy of the report of the [Name] [Title] [Department] [City] [State] [Country] [Date]

and one copy of the report of the [Name] [Title] [Department] [City] [State] [Country] [Date]

and one copy of the report of the [Name] [Title] [Department] [City] [State] [Country] [Date]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-300  
53 7469BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7469

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIE WADE

2. DATE  
OF  
DEATH

8/20/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTE

University Hosp.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto.

16-02

D. STREET ADDRESS (If rural, give location)

1225 N. Parish St.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

6-1-13

9. AGE (In years last birthday)

40

If Under 1 Year Months Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Fla.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Willie Wade

14. MOTHER'S MAIDEN NAME

Sadie Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

-

17. INFORMANT

Madie Wade

ADDRESS

1225 N. Parish St.

18. 703.7

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypoglycemia

INTERVAL BETWEEN ONSET AND DEATH

10 hrs.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ?  
(C) Lymphosarcoma - ?

8 mos.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/19 1953, to 8/20 1953, that I last saw the deceased alive on 8/20 1953, and that death occurred at 203A m., from the causes and on the date stated above.

23A. SIGNATURE

J. N. Wein

23B. ADDRESS

University Hosp.

23C. DATE SIGNED

8/20/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/31/53

24C. NAME OF CEMETERY OR CREMATORY

Mt Auburn, Balto. Md

24D. LOCATION (City, town, or county)

Balto. Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 21 1953

REGISTRAR'S SIGNATURE

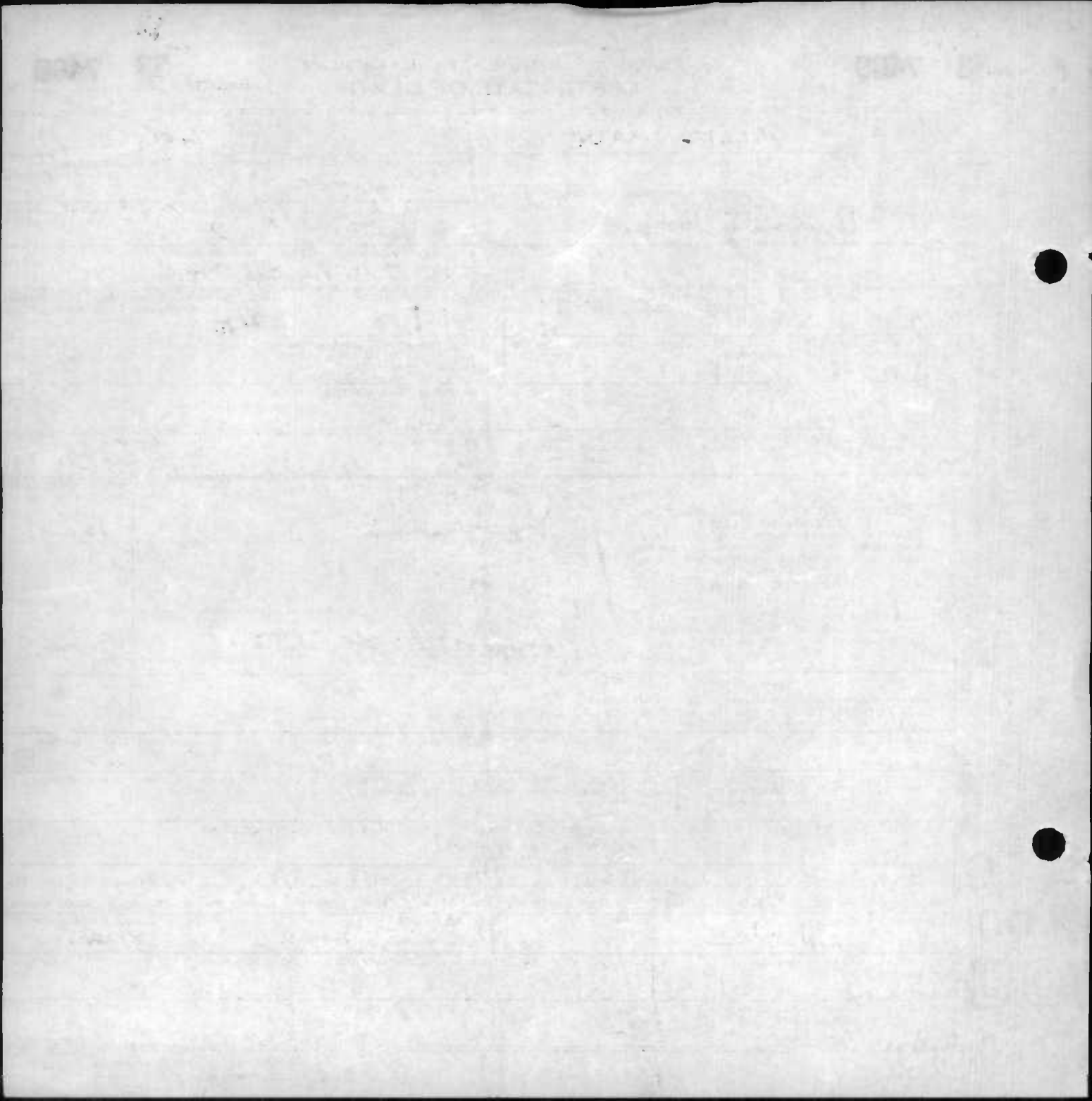
Huntington Williams

25. FUNERAL DIRECTOR

Geo. H. Nelson

ADDRESS

1303





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7470

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

GILBERT DUVALL

2. DATE OF DEATH August 20, 1953

3. PLACE OF DEATH:  
A. Baltimore City, Maryland Maryland Gen Hosp.4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Maryland General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

2026 Mt. Royal Terrace

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
married

8. DATE OF BIRTH

May 21, 1921

9. AGE (In years birthday)

32

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
sheetrock applicator10B. KIND OF BUSINESS OR INDUSTRY  
C. A. Barnes Co.11. BIRTHPLACE (State or foreign country)  
North Carolina12. CITIZEN OF WHAT COUNTRY?  
u.s.

13. FATHER'S NAME

Ephriam Duvall

14. MOTHER'S MAIDEN NAME

Mae O'Dell Tillett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W.2

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Calvert Duvall 115 N. Milton Ave

18. ~~E981X~~

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) Gunshot wound of chest and abdomen  
~~xxxx~~ involving heart, liver, and intestines  
with massive peritoneal hemorrhage

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)  
  
(C)II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  
Home (outside)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

2026 Mt. Royal Terrace

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  
Aug. 20, 1953 4:00 P.m.21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot during altercation

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

23A. SIGNATURE

M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

Aug. 21, 1953

24A. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24B. DATE

Aug 21, 1953.

24C. NAME OF CEMETERY OR CREMATORY

Mt. Olive

24D. LOCATION (City, town, or county) (State)

Manteo, North Carolina

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 21 1953

Schlunke Funeral Home

2601-03-05 E. Madison Street.,

VS 151

N 862.4

69036

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE UNITED STATES OF AMERICA

DOCTOR OF MEDICINE

JOHN H. HARRIS

OF THE

STATE OF

MISSISSIPPI

DOCTOR OF MEDICINE

JOHN H. HARRIS

OF THE

STATE OF

MISSISSIPPI

DOCTOR OF MEDICINE

JOHN H. HARRIS

OF THE

STATE OF

MISSISSIPPI

DOCTOR OF MEDICINE

JOHN H. HARRIS

OF THE

STATE OF

MISSISSIPPI

DOCTOR OF MEDICINE

JOHN H. HARRIS

OF THE

STATE OF

MISSISSIPPI

DOCTOR OF MEDICINE

JOHN H. HARRIS

OF THE

K-656

53 7471

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7471

1. NAME OF DECEASED (Type or Print) <b>Francis Anthony Koerner</b>		2. DATE OF DEATH <b>August 20, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Doctor's Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
C. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>1207 S. Charles St.</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Jan. 24, 1903</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Louis Heying Co.</b>	9. AGE (In years last birthday) <b>50yrs</b>
13. FATHER'S NAME <b>George Koerner</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
16. SOCIAL SECURITY NO. <b>none</b>		14. MOTHER'S MAIDEN NAME <b>Marie Vorath</b>	
17. INFORMANT <b>Nellie N. Koerner</b>		ADDRESS <b>1207 S. Charles St.</b>	
18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Hemorrhage</b> DUE TO <b>Hypertensive Cardio-vascular Dis.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) Cerebral Hemorrhage</b> <b>(B) Hypertensive Cardio-vascular Dis.</b> <b>(C)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 yr.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>8/20/53</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>8/18/53</b> , 19__, to __, 19__, that I last saw the deceased alive on <b>8/20/53</b> , 19__, and that death occurred at <b>5 A.M.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Nellie N. Koerner</b>		23B. ADDRESS <b>102 E. Fort Ave</b>	
23C. DATE SIGNED			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 22, 1953</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Ritchie Highway Balto. Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 21 1953</b>		25. FUNERAL DIRECTOR <b>KRAUSE FUNERAL HOME 1216 S. Charles</b>	

500 44 472

MAY 28

1953

CERTIFICATE OF DEATH

MAY 28

Blank certificate form with horizontal lines for text entry.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. **53 7472**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)**MINNIE COLLINS. (WILSON.)**2. DATE  
OF  
DEATH**8/20/53**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION**University Hoosp.**

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE **Md.**

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**Balta.****25-01**

D. STREET ADDRESS (If rural, give location)

**114 W. Hamburg St.**

C. Length of stay in Baltimore

**30**Yrs.  
Mos.  
Days

5. SEX

**F**

6. COLOR OR RACE

**C**7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)**MARRIED**

8. DATE OF BIRTH

**12-15-03-49**9. AGE (In years,  
last birthday)If Under 1 Year  
Months Days**8 5**If Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)**House wife**10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Pennsylvania**12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

**Manuel Glean ?**

14. MOTHER'S M maiden NAME

**Nancy ?**15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

**James Collins 114. ADDRESS  
Hamburg St**18. **420.0**

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

**Intractable congestive failure**

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

**Myocardial infarction**

(C) DUE TO

**Arteriosclerotic Heart Disease**INTERVAL BETWEEN  
ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

**Pneumonia**

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **8/3**, 19**53**, to **8/20**, 19**53**, that I last saw the  
deceased alive on **8/19/53**, 19**53**, and that death occurred at **5:55 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE

**J. W. Uleria**

M. D.

23B. ADDRESS

**University Hoosp.**

23C. DATE SIGNED

**8/29/53**24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)**BURIAL**

24B. DATE

**8/23/53**

24C. NAME OF CEMETERY OR CREMATORY

**MT. CALVARY - CEM.**

24D. LOCATION (City, town, or county)

**BALTIMORE**

(State)

**Md.**DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**William J. Jackson**

25. FUNERAL DIRECTOR

**William J. Jackson**

ADDRESS

STAT 76

115

11-18-1913

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]*



5-315

53 7478

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7473

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Mary Emma Stevenson</i>		2. DATE OF DEATH <i>8/19/53</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>611 Greenwillow</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Balt.</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>611 Greenwillow</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balt.</i>	
Length of stay in Baltimore <i>60</i> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>611 Greenwillow</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>Negro</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>1893</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>housewife</i>	9. AGE (In years last birthday) <i>60</i>
11. BIRTHPLACE (State or foreign country) <i>Balt Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>James Vandewater</i>		14. MOTHER'S MAIDEN NAME <i>Mary Branson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Herboud</i> ADDRESS <i>611 Greenwillow</i>

18. <i>591x</i>	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, apnea, etc. It means the disease, injury or complication which caused death.)	(A) <i>Chemia</i>	DUE TO	<i>1 mth</i>
ANTECEDENT CAUSES	(B) <i>nephroses</i>	DUE TO	<i>2 yrs</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION <i>0</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

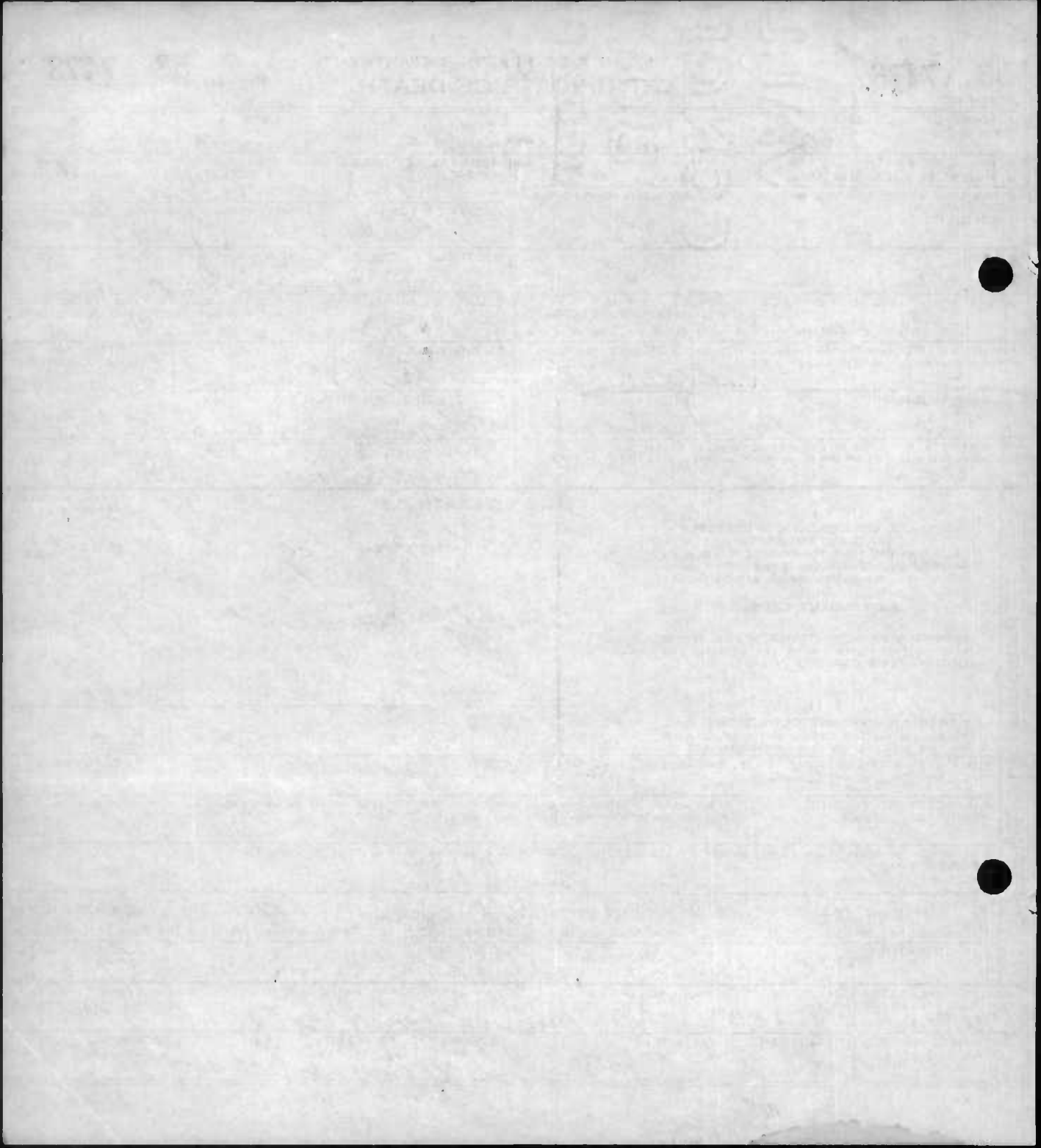
22. I hereby certify that I attended the deceased from *6/1*, 1953, to *8/19*, 1953 that I last saw the deceased alive on *8/18*, 1953, and that death occurred at *9:05* a. m., from the causes and on the date stated above.

23A. SIGNATURE <i>C. G. Wellington</i>	23B. ADDRESS <i>753 George St</i>	23C. DATE SIGNED <i>8/19/53</i>
--	-----------------------------------	---------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>8/24/53</i>	24C. NAME OF CEMETERY OR CREMATORY <i>MT. AUBURN CEM. BALTO</i>	24D. LOCATION (City, town, or county) (State) <i>Md</i>
---	--------------------------	---	---

DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 21 1953</i>	REGISTRAR'S SIGNATURE <i>Huntington</i>	25. FUNERAL DIRECTOR <i>William Jackson</i>	ADDRESS
---	---	---	---------

MEDICAL CERTIFICATION



J. 525

53 7474

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7474

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HARVEY JOHNSON

2. DATE  
OF  
DEATH

Aug. 18, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

Provident Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto.

D. STREET ADDRESS (If rural, give location)

1205 Springfield Ave. Wilson Park

Length of stay in Baltimore

40 yrs?

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Armistead Johnson

14. MOTHER'S MAIDEN NAME

Madenin Bennis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Hospital Record

## CAUSE OF DEATH

18. 443X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Cardiovascular Accident

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Hypertension

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Chronic Rheumatoid Arthritis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-17-53 to 8-18-53, that I last saw the deceased alive on 8-18-53, and that death occurred at 11:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

George W. Legner M. D.

23B. ADDRESS

Provident Hospital

23C. DATE SIGNED

8-19-53

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 21 1953

Huntington

Charles Sanders

VS 150

76174

217 E. Preston St

MEDICAL CERTIFICATION

1000

THE UNIVERSITY OF MICHIGAN LIBRARY

ANN ARBOR, MICHIGAN

1000

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **53 7475**

**53 7475**

1. NAME OF DECEASED (Type or Print) <b>EUGENE COMEGYS</b>		2. DATE OF DEATH <b>August 19, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Morgue</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>1825 W. Lexington Street</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>Sept. 24, 1928</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>24</b> If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Comegys</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Geo. Comegys</b>		ADDRESS <b>825 W. Lexington St.</b>	
18. <b>570.3</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Intestinal obstruction</b> DUE TO <b>volvulus of large intestine with gangrene of large intestine and acute peritonitis</b> ANTECEDENT CAUSES <b>Atrophy of brain</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Megacolon</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <u>Autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
23A. SIGNATURE <i>William V. ...</i>		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>	
23C. DATE SIGNED <b>August 19, 1953</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>8/22/53</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>W. ... Cem.</b>		24D. LOCATION (City, town or county) (State) <b>Balto. Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 21 1953</b>		REGISTRAR'S SIGNATURE <i>...</i>	
25. FUNERAL DIRECTOR <b>Mrs. Katie Williams</b>		ADDRESS <b>322 N. ...</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1000

1000

1000





B-652

53 7476

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7476  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Edward J. Barnes** 2. DATE OF DEATH **8-20-53**3. PLACE OF DEATH:  
A. Baltimore City, Maryland 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **MARYLAND** B. COUNTY **A.A.**B. FULL NAME OF (If not in hospital or institution, give street address or location)  
**LUTHERAN HOSPITAL** C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**A.A. County - Brooklyn**D. STREET ADDRESS (If rural, give location)  
**5100 Brookwood Rd. 5250**5. SEX **M** 6. COLOR OR RACE **W** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
**MARRIED** 8. DATE OF BIRTH **3 Nov. 1919** 9. AGE (In years last birthday) **33** 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
**APPRENTICE PRESSMAN** 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country)  
**MD.** 12. CITIZEN OF WHAT COUNTRY?13. FATHER'S NAME **CHARLES E. BARNES** 14. MOTHER'S MAIDEN NAME  
**AUGUSTA HELDMAN**15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **YES W.W. II** 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS  
**MRS. MARIA BARNES, 5100 Brookwood Rd.**18. **561.0** CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH  
**3 wks.**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
**Abdominal abscess and Right retro-peritoneal abscess**ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
**Free Gangrene of ascending colon & small bowel**(C) **Incarcerated inguinal (rt) Hernia**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **8-2-53** 19B. MAJOR FINDINGS OF OPERATION **INCARCERATED RT. INGUINAL HERNIA** 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?22. I hereby certify that I attended the deceased from **7-27-53**, 19**53** to **8-20**, 19**53**, that I last saw the deceased alive on **8-20**, 19**53**, and that death occurred at **9:11 P.M.**, from the causes and on the date stated above.23A. SIGNATURE **James L. Gray** M. D. 23B. ADDRESS **Lutheran Hosp. -** 23C. DATE SIGNED **8/21/53**24A. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** 24B. DATE **8/24/53** 24C. NAME OF CEMETERY OR CREMATORY **U.S. NATIONAL** 24D. LOCATION (City, town, or county) (State) **BALTIMORE, MD.**DATE RECEIVED BY LOCAL REGISTRAR **AUG 21 1953** REGISTRAR'S SIGNATURE **Huntington** 25. FUNERAL DIRECTOR **Wm. T. D. Inc.** ADDRESS **1217 ST. PAUL ST.**VS 150 **613 4M**

MEDICAL CERTIFICATION

Chinese J. Brown

Chinese J. Brown

Chinese J. Brown

Chinese J. Brown

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Chinese J. Brown

Chinese J. Brown

Chinese J. Brown

C-636

3 7477

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7477

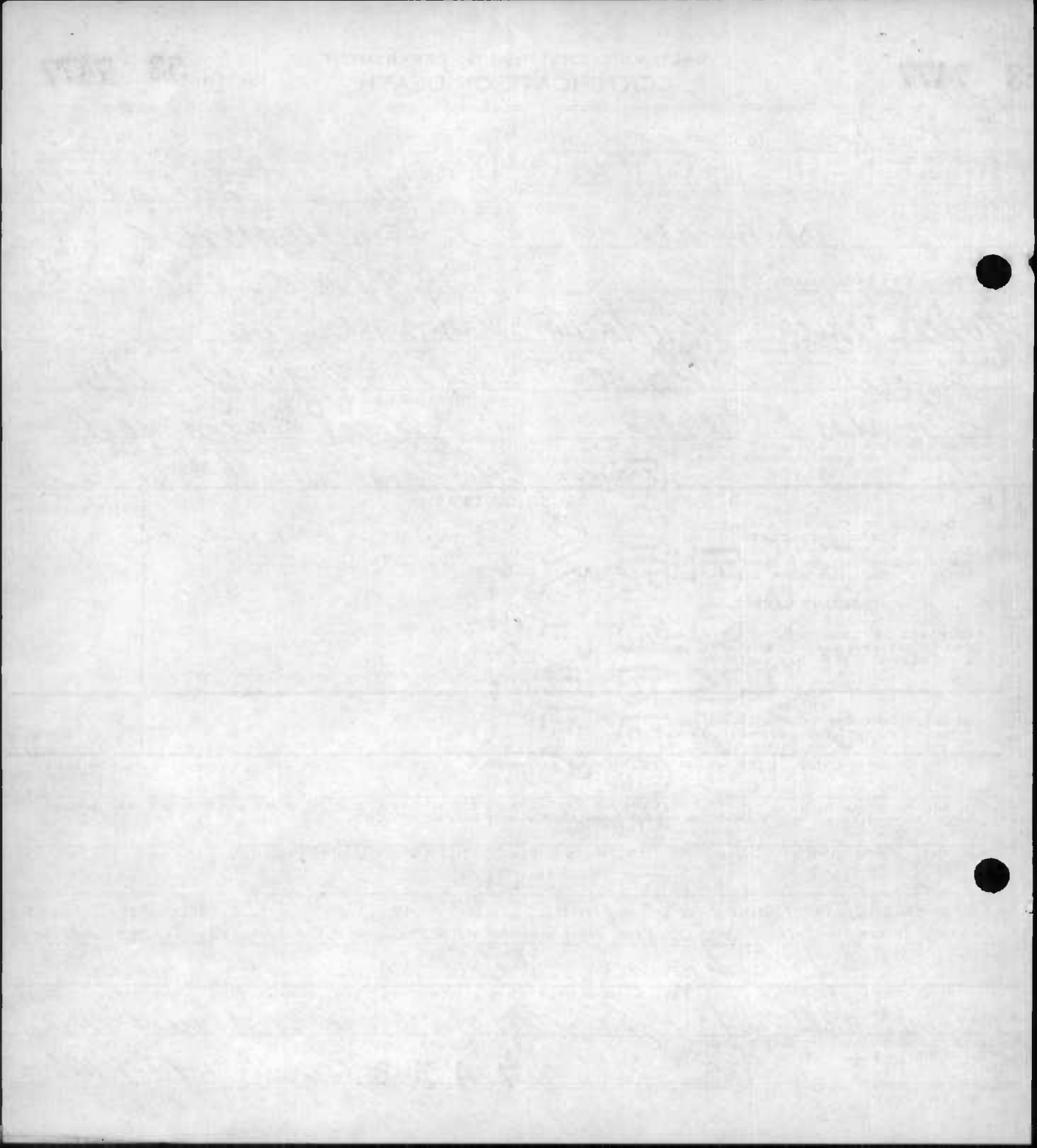
1. NAME OF DECEASED (Type or Print) <i>Wilbur E. Carter</i>		2. DATE OF DEATH <i>8/21/53</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>3919 Park Heights</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore City</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>at home</i>		C. CITY OR TOWN (if outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
D. STREET ADDRESS (if rural, give location) <i>3919 Park Heights Dr</i>		E. CITY OR TOWN (if outside corporate limits, write RURAL and give township)	
F. LENGTH OF STAY IN BALTIMORE		G. DATE OF BIRTH <i>Nov-12-1852</i>	
H. AGE (In years last birthday) <i>100</i>		I. AGE (In years last birthday) <i>100</i>	
J. AGE (In years last birthday) <i>100</i>		K. AGE (In years last birthday) <i>100</i>	
L. AGE (In years last birthday) <i>100</i>		M. AGE (In years last birthday) <i>100</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Plumber</i>	
11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Francis E. Carter</i>		14. MOTHER'S MAIDEN NAME <i>Caroline E. Lemmon</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Wm. J. P. Johnson</i>		18. ADDRESS <i>403 Med Arts Bldg</i>	
19. DATE OF OPERATION <i>0</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1925</i> , to <i>Aug 21</i> , <i>1953</i> , that I last saw the deceased alive on <i>8/21</i> , <i>1953</i> , and that death occurred at <i>6a</i> m., from the causes and on the date stated above.			
23A. SIGNATURE <i>Wm. J. P. Johnson</i>		23B. ADDRESS <i>403 Med Arts Bldg</i>	
23C. DATE SIGNED <i>8-21-53</i>		23D. DATE SIGNED	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Aug 24</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore MD</i>	
25. FUNERAL DIRECTOR <i>Wm. J. P. Johnson</i>		25. FUNERAL DIRECTOR <i>Wm. J. P. Johnson</i>	
25. FUNERAL DIRECTOR <i>Wm. J. P. Johnson</i>		25. FUNERAL DIRECTOR <i>Wm. J. P. Johnson</i>	

MEDICAL CERTIFICATION

1937 82

OFFICE OF THE SECRETARY OF THE ARMY  
WASHINGTON, D. C.

1937 82



G-365

53 7478

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7478

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Gutermuth George

2. DATE  
OF  
DEATH

8-19-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore Md.

B. FULL NAME OF INSTITUTION OR HOSPITAL OR INSTITUTION  
FRANKLIN HOSPITAL  
Casey St. & Calhoun St.  
Baltimore Maryland4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)  
A. STATE Md. B. COUNTY D.C.C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)  
Balto. RuralD. STREET ADDRESS (If rural, give location)  
Hammonds Lane 5250

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

18. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) A. C. V. Disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Pulmonary edema

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) emphysema, chronic myocarditis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 8:15 P.M., 1953, to 8:19 P.M., 1953, that I last saw the deceased alive on 8:19 P.M., 1953 and that death occurred at 8:19 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

2903U

MEDICAL CERTIFICATION





P-160  
53 7479BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7479

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ELLA-MAY-PFEIFER

2. DATE  
OF  
DEATH

Aug 20, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland 428 Westgate Road

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
A. STATE B. COUNTY before admission)

Md

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution give street address or  
location)C. CITY OR TOWN (If outside corporate limits, write full name and give  
township)

Baltimore 28-04

Length of stay in Baltimore

Lifetime

Yrs.  
Mos.  
DaysD. STREET ADDRESS (If rural, give location)  
428 Westgate Road

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Mar 7, 1874

9. AGE (In years  
last birthday)

79

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

House Wife

10B. KIND OF BUSINESS OR  
INDUSTRY

at Home

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Francis  
Charles Wilderman

14. MOTHER'S MAIDEN NAME

Mary Wilbur

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

August J. Pfeifer 428 Westgate Rd

ADDRESS

18. 442X I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

Chr. Myocarditis

1945

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Chr. Interstitial Nephritis

1945

DUE TO

(C)

Arterio Sclerosis

1945

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONITION CAUSING IT.INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 5, 1953 to Aug 20, 1953 that I last saw the  
deceased alive on Aug 20, 1953 and that death occurred at 10:15 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Parker Brown

23B. ADDRESS

3602 Liberty Hgts E.

23C. DATE SIGNED

8-20-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

Aug 24, 1953

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston J. Williams

25. FUNERAL DIRECTOR

5311 Edmondson Ave

ADDRESS

STAT 87

STAT 87

73

7

1000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53

7480

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 53 7480

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Ella Walker

2. DATE  
OF  
DEATH

Aug 19, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Ose 4

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Johns Hopkins Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 8-03

D. STREET ADDRESS (If rural, give location)

1107 N. Port St

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Sept.-19-92

9. AGE (In years  
last birthday)

60

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Hospital Records

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Cerebral hemorrhage

48 hrs

ANTECEDENT CAUSES

DUE TO

(B)

Hypertension

15 yr

DUE TO

(C)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II20. AUTOPSY?  
YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/17, 1953 to 8/19, 1953 that I last saw the deceased alive on 8/19, 1953, and that death occurred at 4:00 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Henry M. Warner, Jr.

23B. ADDRESS

23C. DATE SIGNED

8/19/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8-22-53

24C. NAME OF CEMETERY OR CREMATORY

Mt. Liberty Cem

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

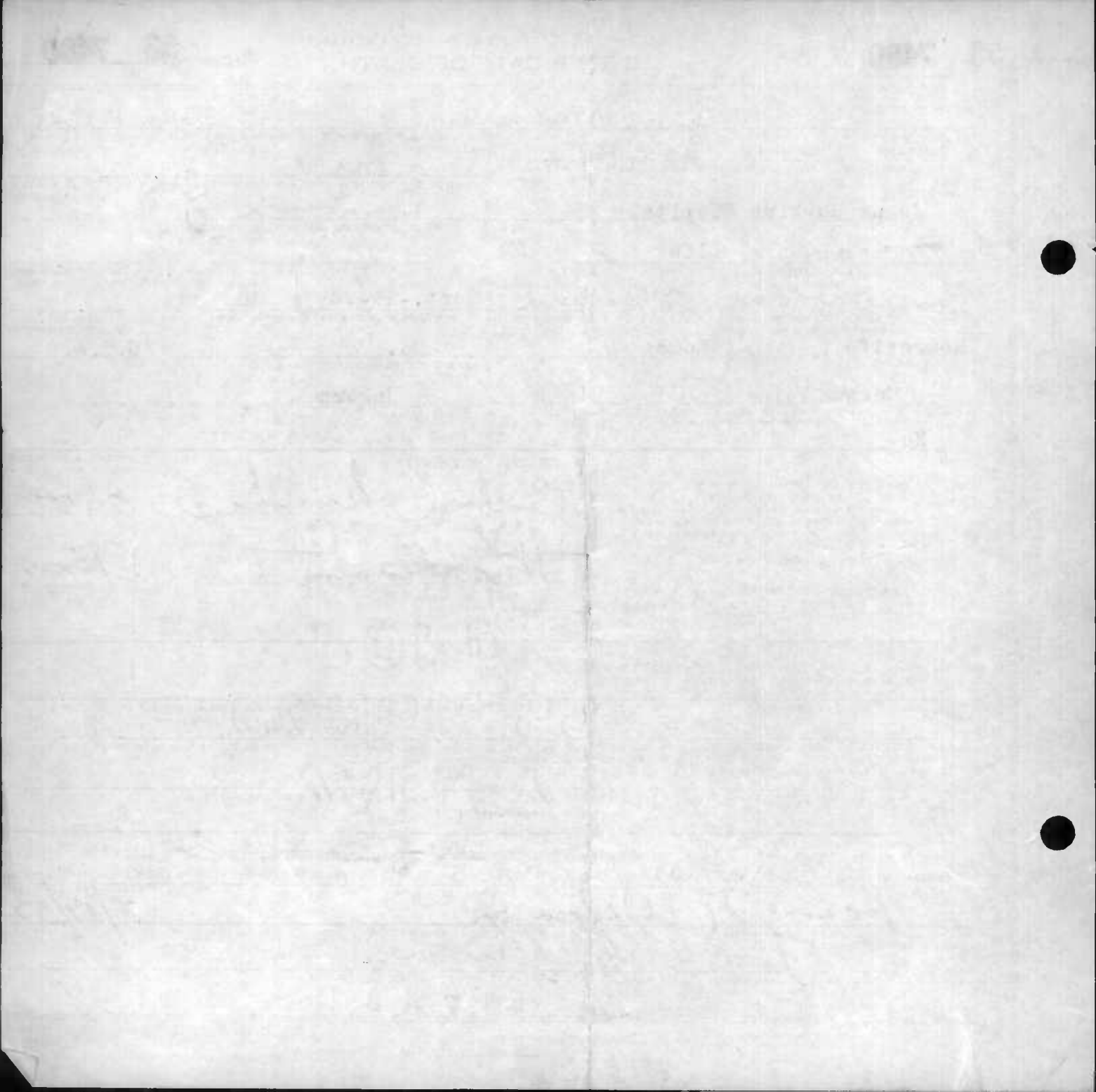
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 21 1953

VS 150



S-530

53 7481

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7481

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mable Smith

2. DATE  
OF  
DEATH

8-19-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Md

B. COUNTY

Balt

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

Provident Hosp.

C. CITY OR TOWN (If outside corporate limits, write full name and give township)

Balt Md

D. STREET ADDRESS (If rural, give location)

1537 Leslie St

Length of stay in Baltimore

37

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Sep.

8. DATE OF BIRTH

2-18-13

9. AGE (In years last birthday)

40

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Wash D.C.

12. CITIZEN OF WHAT COUNTRY?

US

13. FATHER'S NAME

Angus White

14. MOTHER'S MAIDEN NAME

Vernie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Hospital Records

ADDRESS

18. 623X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)(A) Acute left heart failure  
DUE TO of undet. etiology.

INTERVAL BETWEEN ONSET AND DEATH

24-36hrs

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pelvic Inflammatory Disease

undet

19A. DATE OF OPERATION

8/18/53

19B. MAJOR FINDINGS OF OPERATION

Chronic bilateral Salpingo oophoritis @ Chr. Cervicitis

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/30/53, 19\_\_, to 8/19/53, 19\_\_, that I last saw the deceased alive on 7/10/53, 19\_\_, and that death occurred at 8 p. m., from the causes and on the date stated above.

23A. SIGNATURE

William K. Farmer

M. D.

23B. ADDRESS

1514 Division St

23C. DATE SIGNED

8/21/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/31/53

24C. NAME OF CEMETERY OR CREMATORY

Mt Auburn

24D. LOCATION (City, town, or county)

Baltimore Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 21 1953

H. K. Farmer

Geo. H. Nelson

1303

72084 Pressman St

1941

20

CERTIFICATE OF DEATH

181





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7482

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7482

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Thomas Benjamin

2. DATE  
OF  
DEATH

Aug 20, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Med. Tray 2

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

beach

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

33

844

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Rising Sun

D. STREET ADDRESS (If rural, give location)

5700

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male White

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

B. DATE OF BIRTH

6-4-'07

9. AGE (In years  
last birthday)

46

If Under 1 Year  
Months Days

If Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Rufus Benjamin

14. MOTHER'S MAIDEN NAME

Clara Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 456X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

myocarditis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

Lupus Erythematosus disseminata

1 yr.

INTERVAL BETWEEN  
ONSET AND DEATH

3 wks.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-16-1953 to 8-20-1953, that I last saw the  
deceased alive on 8-20-1953 and that death occurred at 4:01 PM, from the causes and on the date stated above.

23A. SIGNATURE

J. C. Vandell, Jr.

23B. ADDRESS

23C. DATE SIGNED

8/21/53

24A. BURIAL CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial Aug. 24, 1953

Hope Well

Port Deposit, R.D. Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 22 1953

Huntington, Williams, Md

25. FUNERAL DIRECTOR

ADDRESS

1. 1000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7483  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>John Moses Glover</i>		2. DATE OF DEATH <i>Aug. 21, 1953</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Maryland</i>		C. CITY OR TOWN <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>2032 Eutaw St.</i>		D. STREET ADDRESS (If rural, give location) <i>2032 Eutaw St.</i>		9. AGE (In years last birthday) <i>83</i>	
c. Length of stay in Baltimore		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		11. BIRTHPLACE (State or foreign country) <i>Spartanburg, Va.</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	8. DATE OF BIRTH <i>Feb. 12, 1869</i>		12. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work dominating most of working life, even if retired) <i>Fireman Iron Foundry</i>		10B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME <i>Isiles Glover</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <i>Lavinia ?</i>	
18. <i>420.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <i>Arteriosclerotic Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B)		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Aug 17, 1953</i> to <i>Aug 21, 1953</i> that I last saw the deceased alive on <i>Aug 20, 1953</i> and that death occurred at <i>12:30 A.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Lercival P. Smith</i>		23B. ADDRESS <i>1709 Swynns Falls Pkwy.</i>		23C. DATE SIGNED <i>8-21-53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>Aug. 21, 1953</i>		24C. NAME OF CEMETERY OR CREMATORY <i>last Cleveland Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Cleveland Ohio</i>		25. FUNERAL DIRECTOR <i>1603, Daniel Hill Ave</i>		26. ADDRESS	
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 22 1953</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i>		27. SIGNATURE	

3815 52

3815 52

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-620

CERTIFICATE AMENDED 9/14/53 ES

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

53 7484

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HENRY MERISCHE

2. DATE  
OF  
DEATH

AUG. 20 - 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Maryland Anne Arundel  
Maryland Park (Ellen Bessie P.O.)

D. STREET ADDRESS (If rural, give location)

5 Beach Road

5200

c. Length of stay in Baltimore

1 day

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

4/30/1910

9. AGE (in years;  
last birthday)

83

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Barber (retired)

10B. KIND OF BUSINESS OR  
INDUSTRY

Self-employed

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown Meisch

14. MOTHER'S MARDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

None

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

Mrs. Ellen M. Deen Mary

ADDRESS

18.

792X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

Uremia

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Burns (nothing to do with  
death)

DUE TO

(over)

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONOITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH. ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/19, 1953, to 8/20, 1953, that I last saw the  
deceased alive on 8/20, 1953, and that death occurred at 4:40 a.m., from the causes and on the date stated above.

23A. SIGNATURE

John K. Pearson, M.D.

23B. ADDRESS

23C. DATE SIGNED

8/26/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

8/22/53

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Park Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

AUG 22 1953

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

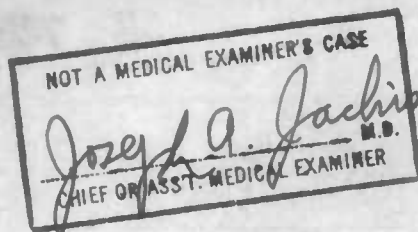
FEDERAL DIRECTOR

FEDERAL DIRECTOR

W. H. Lighter

ADDRESS

Ellen Bessie, Md.



See letter in file from

Dr. J. s. A. Jachimczyk, Msst. Med. Exam.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PROHIBITED FOR BINDING

(2) B-643

53 7485

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7485  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>Andrew B. Barnett.</b>			2. DATE OF DEATH <b>20 Aug 53</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hosp. of Md.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
C. Length of stay in Baltimore <b>Life</b> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>711 Rosedale Street</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>28 Feb 1882</b>		9. AGE (In years last birthday) <b>71</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET. CLERK</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>CAREY MACHINE SUPPLY CO. BALTO. MD.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>JAMES BARNETT</b>			14. MOTHER'S MAIDEN NAME <b>MARTHA</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>212-07-5321A</b>		
17. INFORMANT <b>MRS SARAH A. Barnett</b>			ADDRESS <b>711 Rosedale St.</b>		
18. <b>541.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Renal failure (lower nephron nephrosis)</b>			CAUSE OF DEATH (A) <b>Gastrointestinal hemorrhage</b> DUE TO (B) <b>massive</b> DUE TO (C) <b>Duodenal ulcer.</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>years.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>7 days.</b> <b>7 days.</b>		
19A. DATE OF OPERATION <b>0</b>			19B. MAJOR FINDINGS OF OPERATION		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>3 Aug 1953</b> , to <b>20 Aug 1953</b> , that I last saw the deceased alive on <b>20 Aug 1953</b> , and that death occurred at <b>4:00 p. m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Richard E. Beul</b>			23B. ADDRESS <b>Lutheran Hosp.</b>		23C. DATE SIGNED <b>20 Aug 53</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 24/53</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 22 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>		25. FUNERAL DIRECTOR <b>Harry W. Witzke</b>	
				ADDRESS <b>4101 Edmondson Ave.</b>	

39064



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 <b>7486</b>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		53 <b>7486</b> Registered No.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Margaret Jane Evans</b>		2. DATE OF DEATH <b>8-19-53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>before admission</b>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>US PHS Hospital</b> <b>Baltimore 11, Md.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>			
c. Length of stay in Baltimore <b>30</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>3310 West Franklin Street</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Sept. 9, 1874</b>	9. AGE (In years last birthday) <b>78</b>	10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Benedict Brown</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Jane Van Lanningham</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT ADDRESS <b>Records, USPHS Hospital, Balto., 11, Md</b>	
18. <b>151X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Aspiration pneumonia, left lower lobe secondary to</b>		CAUSE OF DEATH <b>Aspiration pneumonia, left lower lobe secondary to</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Recent</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Carcinoma stomach with metastases to liver, abdominal lymph nodes, and right leaf of diaphragm.</b>		(B) DUE TO <b>Carcinoma stomach with metastases to liver, abdominal lymph nodes, and right leaf of diaphragm.</b>		(C) DUE TO <b>8 months</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>7</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		19C. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <b>7-3-53</b> , 19 <b>53</b> , to <b>8-19-53</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>8-19-53</b> , 19 <b>53</b> , and that death occurred at <b>1:00 P.</b> , from the causes and on the date stated above.		23A. SIGNATURE <b>J.A. Hunter, Medical Director</b>	
23B. ADDRESS <b>USPHS Hospital, Balto., 11, Md.</b>		23C. DATE SIGNED <b>8-19-53</b>		24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>Aug. 22/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>		24D. LOCATION (City, town, or county) (State) <b>Glenburnie, Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 22 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		FUNERAL DIRECTOR ADDRESS <b>4101 Edmondson Ave</b>	
VS 150					

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53

7487

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7487  
Registered No.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

MARY

ELIZABETH

CAIN

2. DATE

OF DEATH

August 21, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

St. Joseph's Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3804 Greenmount Avenue

c. Length of stay in Baltimore

31

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

May 30, 1898

9. AGE (In years last birthday)

55

If Under 1 Year Months Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

St. Joseph Hospital

10B. KIND OF BUSINESS OR INDUSTRY

Nurse

11. BIRTHPLACE (State or foreign country)

Hickory, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

J. Matthew Cain

14. MOTHER'S MAIDEN NAME

Mary Catherine Blake

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

215-32-1502

17. INFORMANT

Joseph Cain

ADDRESS

Bel Air Md

18. E 900.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Skull fracture

~~NOISE~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

(B) Contusion of brain

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

Home (outside)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

3804 Greenmount Avenue

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

Aug. 21, 1953 11:00 A.m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Slipped on cellar steps &amp; struck head

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William H. H. H.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ M.D. MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

Aug. 21, 1953

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8 - 24 - 53

24C. NAME OF CEMETERY OR CREMATORY

Bel Air Memorial Gardens

24D. LOCATION (City, town, or county)

Bel Air, Maryland

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 22 1953

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Joseph P. B. B.

ADDRESS

Bel Air Md

VS 151

N 803.2

05887

1957

1957

1957

1957



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T-520  
53 7488

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7488  
Registered No.

BIRTH NO.		
1. NAME OF DECEASED (Type or Print) <b>HENRIETTA GAITHER JONES</b>		
2. DATE OF DEATH <b>8/20/53</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland		
4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>11-09</b>		
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSP.</b>		
6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE-17</b>		
7. STREET ADDRESS (If rural, give location) <b>216 W. LANVALE ST.</b>		
8. Length of stay in Baltimore <b>LIFE</b> Yrs. Mos. Days		
9. SEX <b>F</b>	10. COLOR OR RACE <b>W</b>	11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>S</b>
12. DATE OF BIRTH <b>11/13/1880</b>		
13. AGE (In years last birthday) <b>72</b>		
14. Under 1 Year Months: Days		
15. Under 24 Hours Hours: Min.		
16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		
17. KIND OF BUSINESS OR INDUSTRY <b>-</b>		
18. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		
19. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
20. FATHER'S NAME <b>ALBERT JONES</b>		
21. MOTHER'S MAIDEN NAME <b>MARGARET A. POOLE</b>		
22. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>-</b> (If yes, give war or dates of service)		
23. SOCIAL SECURITY NO. <b>-</b>		
24. INFORMANT <b>BROTHER</b> ADDRESS <b>109 RECORD ST. FREDERICK, MD.</b>		
25. CAUSE OF DEATH		
26. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		
27. ANTECEDENT CAUSES		
28. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
29. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
30. DATE OF OPERATION <b>0</b> 31. MAJOR FINDINGS OF OPERATION		
32. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
33. 21A. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		
34. 21B. PLACE OF INJURY (e. g., io or about home, farm, factory, street, office bldg., etc.)		
35. 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
36. 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		
37. 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		
38. 21F. HOW DID INJURY OCCUR?		
39. 22. I hereby certify that I attended the deceased from <b>8/19</b> , 19 <b>53</b> , to <b>8/20</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>8/20</b> , 19 <b>53</b> , and that death occurred at <b>1:45 A.M.</b> , from the causes and on the date stated above.		
40. 23A. SIGNATURE <b>Henry B. Knock, Jr.</b> M. D. 41. 23B. ADDRESS <b>Union Memorial Hosp.</b> 42. 23C. DATE SIGNED <b>8/20/53</b>		
43. 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		
44. 24B. DATE <b>8-22-53</b>		
45. 24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		
46. 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		
47. DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 22 1953</b>		
48. REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		
49. 52. FUNERAL DIRECTOR <b>John O. Mitchell &amp; Sons, Inc.</b> ADDRESS <b>1900 Eutaw Place</b>		



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-630  
53 7489BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7489

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Nettie Howard

2. DATE  
OF  
DEATH

August 20, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE  
Maryland

B. COUNTY before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

1419 Homestead Street

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1419 Homestead Street

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

July 7, 1876

9. AGE (in years

77

last birthday) If Under 1 Year

Months: Days

If Under 24 hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore County, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Joseph Vase

14. MOTHER'S MAIDEN NAME

Sophia

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Eva Goodrich, 3500 14th St., N.W.

Washington, D. C.

18. 450.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

5.10 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypertension CVD

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1952, to Aug 20, 1953, that I last saw the deceased alive on Aug 18, 1953, and that death occurred at 8:45 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

8/24/53

24C. NAME OF CEMETERY OR CREMATORY

Mt. Olivet Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 22 1953

Huntington Williams, M.D.

A. M. Clark, Jr.

1217 St. Paul Street

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J-652  
53 7490

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 7490  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ALPHONS GERMACK</b>			2. DATE OF DEATH <b>8/21/53</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALT.</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNION MEM. HOSP</b>			C. CITY OR TOWN (If outside corporate limits, write R.U.R. and give township) <b>BALTIMORE 20-02</b>		
D. STREET ADDRESS (If rural, give location) <b>2315 EDMONDSON AVE.</b>			5. LENGTH OF STAY IN BALTIMORE <b>LIFE</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>12/11/66</b>	9. AGE (In years last birthday) <b>86</b>	10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Motorman (rtd)</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Transportation</b>		
11. BIRTHPLACE (State or foreign country) <b>MD.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>THOMAS GERMACK</b>			14. MOTHER'S MAIDEN NAME <b>MARGARET SEITZ</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>212-16-5786</b>		
17. INFORMANT <b>Mrs. Anna Germack-2315 Edmondson Ave.</b>			ADDRESS		

18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>MYOCARDIAL INFARCTION</b> DUE TO (B) <b>GENERAL ATHEROSCLEROSIS</b> DUE TO (C) <b>BILAT. UPPER LOBAR PNEUMONIA - CONGESTIVE HEART FAILURE</b> <b>ATHEROSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>7</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 29, 1953</b> to <b>Aug 21, 1953</b> , that I last saw the deceased alive on <b>July 21, 1953</b> and that death occurred at <b>9:30 AM.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Earle E. Spencer Jr.</b>		M. D.		23B. ADDRESS <b>UMH</b>	
23C. DATE SIGNED <b>8/21/53</b>					
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/21/53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>					
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 22 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>Wm. J. W. Baker &amp; Sons</b> <b>Balto. 17, Md.</b>	





M-655

53 7491

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7491

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Merryman, (Neal) Thomas Nealand

2. DATE  
OF

DEATH August 21, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

St. Joseph's

C. CITY OR TOWN

Maryland

(If outside corporate limits, write RURAL, and give township)

D. STREET ADDRESS (If rural, give location)

5108 Richard Avenue

5. SEX

M.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

OCT. 2-1890

9. AGE (In years

last birthday)

62

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Bricklayer

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

HATTIE M<sup>c</sup> Kenzie15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

MRS Ellen (Nellie) Merryman - SAME

18. 002X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Pulmonary tuberculosis, left upper lobe

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Pott's disease, tuberculous, 9-11th

DUE TO

(C) thoracic vertebrae

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐  
WORKNOT WHILE ☐  
AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 9, 1953, to August 21, 1953 that I last saw the  
deceased alive on August 21, 1953, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

Carlo Formel

23B. ADDRESS

M. D.

1100 N. Caroline Street

23C. DATE SIGNED

Aug. 21, 1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 22 1953

Huntington Williams, M.D.

Ruck

5305 Harford Rd



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-240  
53' 7492

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7492

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Michel. Maria. B</i>		2. DATE OF DEATH <i>8/20/53</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>38 University Hospital.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 5300</i>			
c. Length of stay in Baltimore <i>life.</i>		D. STREET ADDRESS (If rural, give location) <i>2818 Emerald. Rd June 14</i>			
5. SEX <i>F.</i>	6. COLOR OR RACE <i>w.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married.</i>	8. DATE OF BIRTH <i>May 30, 1906</i>	9. AGE (In years last birthday) <i>47</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house wife.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>
13. FATHER'S NAME <i>John. Heid.</i>		14. MOTHER'S MAIDEN NAME <i>Mary. B. Grebner</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>John. B. Michel. same.</i>	
18. <i>193X</i>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Brain. neoplasm - respiratory failure.</i>			
ANTECEDENT CAUSES		(B) <i>3 wks.</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>8/18/53.</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Brain Neoplasm.</i>		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>8-13</i> , 1953, to <i>8-20</i> , 1953, that I last saw the deceased alive on <i>8/20</i> , 1953, and that death occurred at <i>6:45 P</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Rafael Lopez Cardus</i>		23B. ADDRESS <i>University Hospital</i>		23C. DATE SIGNED <i>8/20/53</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Aug 24-1953</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltn Md</i>		25. FUNERAL DIRECTOR <i>Leandro J. Kuck 5305 Harford</i>			
DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 22 1953</i>		REGISTRAR'S SIGNATURE <i>Huntington</i>			
VS 150					

1944

1944

C-625  
53 7493

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7493

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>AGNES CIERZNIAK</b>		2. DATE OF DEATH <b>August 21, 1953</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>610 S. Bethel Street</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore <b>Life</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>610 S. Bethel Street</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>January 27, 1894</b>
			9. AGE (In years last birthday) <b>59</b> If Under 1 Year Months Days If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Charwoman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Electric Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Cierzniak</b>		14. MOTHER'S MAIDEN NAME <b>Michaline Janowska</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>-</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212 079 042</b>	
		17. INFORMANT ADDRESS <b>Mr. Henry Cierzniak, 811 S. Streeper Street</b>	

18. <b>155X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Liver</b> (A) DUE TO ANTECEDENT CAUSES <b>Carcinoma of Bile Duct</b> (B) DUE TO (C)	CAUSE OF DEATH <b>Carcinoma of Liver</b> <b>Carcinoma of Bile Duct</b>	INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b> <b>?</b>
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II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
1D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **June 10, 1953** to **Aug 21, 1953**, that I last saw the deceased alive on **Aug 20, 1953** and that death occurred at **12:00 Am.**, from the causes and on the date stated above.

23A. SIGNATURE <b>Joseph Pokorny</b> M. D.	23B. ADDRESS <b>2200 E Madison St</b>	23C. DATE SIGNED <b>8/21/53</b>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8/24/53</b>	24C. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>	24D. LOCATION (City, County, State) <b>Baltimore, Maryland</b>
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DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 22 1953</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	25. FUNERAL DIRECTOR ADDRESS <b>SADOWSKI &amp; SONS, 1808 EASTERN AVENUE</b>
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753 5E **Charles A. Sadowski**

MEDICAL CERTIFICATION

STATE OF NEW YORK

IN SENATE  
January 12, 1909

REPORT  
OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1908

ALBANY:  
J.B. LIPPINCOTT & COMPANY  
PRINTERS  
1909



J-625  
53 7494

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7494

1. NAME OF DECEASED (Type or Print) <b>CHARLES GROSSMAN</b>			2. DATE OF DEATH <b>8-21-53</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE</b>		
D. STREET ADDRESS (If rural, give location) <b>2439 LAKEVIEW AVE.</b>			E. LENGTH OF STAY IN BALTIMORE <b>63</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>DEC. 28, 1889</b>		9. AGE (In years last birthday) <b>63</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>GENERAL MOTORS</b>		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>ISAAC GROSSMAN</b>		14. MOTHER'S MAIDEN NAME <b>BESSIE (UNKNOWN BY FAMILY)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral vascular accident</b> DUE TO <b>Hypertensive cardiovascular disease</b> DUE TO <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>			CAUSE OF DEATH <b>Cerebral vascular accident</b> <b>Hypertensive cardiovascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION <b>0</b>			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7/18</b> , 19 <b>53</b> to <b>8-21</b> , 19 <b>53</b> that I last saw the deceased alive on <b>8/21</b> , 19 <b>53</b> , and that death occurred at <b>6:10 pm.</b> , from the causes and on the date stated above.											
23A. SIGNATURE <b>Rand Beasley</b>				23B. ADDRESS <b>Union Memorial Hospital</b>				23C. DATE SIGNED <b>8-21-53</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>8-22-53</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt Zion</b>		24D. LOCATION (City, town or county) (State) <b>Maskeith N. Y.</b>					
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 22 1953</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>				25. FUNERAL DIRECTOR <b>2100 Entaw Pl</b>				ADDRESS	

VS 150  
7806J



H-340

53 7495

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7495  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>EVELYN VIOLA HADLEY</b>		2. DATE OF DEATH <b>8-21-53</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>SO. BALTO. GEN. HOSP.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE - 25</b>	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>5244 FOURTH ST 5250</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>AUG. 13, 1885</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	9. AGE (in years last birthday) <b>68</b>
11. BIRTHPLACE (State or foreign country) <b>BROOKLYN, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <b>MARY ARAMINTA BROTHERS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MR. MARVIN B. HADLEY</b>		ADDRESS <b>5244 FOURTH ST.</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> DUE TO <b>Arteriosclerosis</b> DUE TO <b>Anteriosclerosis</b> DUE TO <b>Anteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>2 yr.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7-3</b> , 19 <b>53</b> to <b>8-21</b> , 19 <b>53</b> that I last saw the deceased alive on <b>8-20</b> , 19 <b>53</b> , and that death occurred at <b>10:50 P.M.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Dr. F. L. Ladd</b>		23B. ADDRESS <b>207 E. Fort Ave.</b>	23C. DATE SIGNED <b>8-22-53</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>8/25/53</b>	24C. NAME OF CEMETERY OR CREMATORY <b>PARKVIEW</b>	24D. LOCATION (City, town, or county) (State) <b>PEORIA, ILL.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 22 1953</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>JOHN F. DENNY, INC.</b>	
		ADDRESS <b>715 LIGHT ST</b>	



L-340  
53 7496BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7496

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>IDA VIRGINIA LYTLE</u>		2. DATE OF DEATH <u>8-22-53</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Harford</u>	
5. FULL NAME OF (If not in hospital or institution, give street address or location) <u>UNION MEMORIAL HOSP.</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>PPLESVILLE</u>	
6. Length of stay in Baltimore <u>54</u> Yrs. <u>Moer</u> Days		D. STREET ADDRESS (If rural, give location) <u>6200</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>OCT. 4, 1898</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>MELCHOR BAKER</u>		14. MOTHER'S MAIDEN NAME <u>MAU STEWART</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Union Memorial Hosp, Baltimore</u>		ADDRESS	

18. <u>570.5</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CORONARY OCCLUSION</u> DUE TO (A) <u>Coronary occlusion</u> (B) <u>arteriosclerosis</u> (C) <u>?</u>	CAUSE OF DEATH <u>Coronary occlusion</u> <u>arteriosclerosis</u> <u>?</u>	INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>?</u>
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II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION <u>8-21-53</u>	19B. MAJOR FINDINGS OF OPERATION <u>Intestinal obstruction</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-17, 1953, to 8-22, 1953, that I last saw the deceased alive on 8-22, 1953, and that death occurred at 10:30 a.m., from the causes and on the date stated above.

22A. SIGNATURE <u>R. B. Caraway Jr.</u>	22B. ADDRESS <u>Baltimore 18 ind.</u>	22C. DATE SIGNED <u>8-22-53</u>
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24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <u>8-25-1953</u>	24C. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL METH.</u>	24D. LOCATION (City, town, or county) (State) <u>NORRISVILLE, HARFORD Co., Md.</u>
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DATE RECEIVED BY LOCAL REGISTRAR <u>AUG 22 1953</u>	REGISTRAR'S SIGNATURE <u>Huntington Williams</u>	25. FUNERAL DIRECTOR <u>Stewart Pa</u>	ADDRESS
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<p>1. NAME OF PROJECT</p>		<p>2. LOCATION</p>	
<p>3. DESCRIPTION OF PROJECT</p>		<p>4. PURPOSE OF PROJECT</p>	
<p>5. ESTIMATED COST</p>		<p>6. ESTIMATED DATE OF COMPLETION</p>	
<p>7. NAME OF OFFICER IN CHARGE</p>		<p>8. NAME OF OFFICER IN CHARGE</p>	
<p>9. NAME OF OFFICER IN CHARGE</p>		<p>10. NAME OF OFFICER IN CHARGE</p>	
<p>11. NAME OF OFFICER IN CHARGE</p>		<p>12. NAME OF OFFICER IN CHARGE</p>	
<p>13. NAME OF OFFICER IN CHARGE</p>		<p>14. NAME OF OFFICER IN CHARGE</p>	
<p>15. NAME OF OFFICER IN CHARGE</p>		<p>16. NAME OF OFFICER IN CHARGE</p>	
<p>17. NAME OF OFFICER IN CHARGE</p>		<p>18. NAME OF OFFICER IN CHARGE</p>	
<p>19. NAME OF OFFICER IN CHARGE</p>		<p>20. NAME OF OFFICER IN CHARGE</p>	
<p>21. NAME OF OFFICER IN CHARGE</p>		<p>22. NAME OF OFFICER IN CHARGE</p>	
<p>23. NAME OF OFFICER IN CHARGE</p>		<p>24. NAME OF OFFICER IN CHARGE</p>	
<p>25. NAME OF OFFICER IN CHARGE</p>		<p>26. NAME OF OFFICER IN CHARGE</p>	
<p>27. NAME OF OFFICER IN CHARGE</p>		<p>28. NAME OF OFFICER IN CHARGE</p>	
<p>29. NAME OF OFFICER IN CHARGE</p>		<p>30. NAME OF OFFICER IN CHARGE</p>	
<p>31. NAME OF OFFICER IN CHARGE</p>		<p>32. NAME OF OFFICER IN CHARGE</p>	
<p>33. NAME OF OFFICER IN CHARGE</p>		<p>34. NAME OF OFFICER IN CHARGE</p>	
<p>35. NAME OF OFFICER IN CHARGE</p>		<p>36. NAME OF OFFICER IN CHARGE</p>	
<p>37. NAME OF OFFICER IN CHARGE</p>		<p>38. NAME OF OFFICER IN CHARGE</p>	
<p>39. NAME OF OFFICER IN CHARGE</p>		<p>40. NAME OF OFFICER IN CHARGE</p>	
<p>41. NAME OF OFFICER IN CHARGE</p>		<p>42. NAME OF OFFICER IN CHARGE</p>	
<p>43. NAME OF OFFICER IN CHARGE</p>		<p>44. NAME OF OFFICER IN CHARGE</p>	
<p>45. NAME OF OFFICER IN CHARGE</p>		<p>46. NAME OF OFFICER IN CHARGE</p>	
<p>47. NAME OF OFFICER IN CHARGE</p>		<p>48. NAME OF OFFICER IN CHARGE</p>	
<p>49. NAME OF OFFICER IN CHARGE</p>		<p>50. NAME OF OFFICER IN CHARGE</p>	
<p>51. NAME OF OFFICER IN CHARGE</p>		<p>52. NAME OF OFFICER IN CHARGE</p>	
<p>53. NAME OF OFFICER IN CHARGE</p>		<p>54. NAME OF OFFICER IN CHARGE</p>	
<p>55. NAME OF OFFICER IN CHARGE</p>		<p>56. NAME OF OFFICER IN CHARGE</p>	
<p>57. NAME OF OFFICER IN CHARGE</p>		<p>58. NAME OF OFFICER IN CHARGE</p>	
<p>59. NAME OF OFFICER IN CHARGE</p>		<p>60. NAME OF OFFICER IN CHARGE</p>	
<p>61. NAME OF OFFICER IN CHARGE</p>		<p>62. NAME OF OFFICER IN CHARGE</p>	
<p>63. NAME OF OFFICER IN CHARGE</p>		<p>64. NAME OF OFFICER IN CHARGE</p>	
<p>65. NAME OF OFFICER IN CHARGE</p>		<p>66. NAME OF OFFICER IN CHARGE</p>	
<p>67. NAME OF OFFICER IN CHARGE</p>		<p>68. NAME OF OFFICER IN CHARGE</p>	
<p>69. NAME OF OFFICER IN CHARGE</p>		<p>70. NAME OF OFFICER IN CHARGE</p>	
<p>71. NAME OF OFFICER IN CHARGE</p>		<p>72. NAME OF OFFICER IN CHARGE</p>	
<p>73. NAME OF OFFICER IN CHARGE</p>		<p>74. NAME OF OFFICER IN CHARGE</p>	
<p>75. NAME OF OFFICER IN CHARGE</p>		<p>76. NAME OF OFFICER IN CHARGE</p>	
<p>77. NAME OF OFFICER IN CHARGE</p>		<p>78. NAME OF OFFICER IN CHARGE</p>	
<p>79. NAME OF OFFICER IN CHARGE</p>		<p>80. NAME OF OFFICER IN CHARGE</p>	
<p>81. NAME OF OFFICER IN CHARGE</p>		<p>82. NAME OF OFFICER IN CHARGE</p>	
<p>83. NAME OF OFFICER IN CHARGE</p>		<p>84. NAME OF OFFICER IN CHARGE</p>	
<p>85. NAME OF OFFICER IN CHARGE</p>		<p>86. NAME OF OFFICER IN CHARGE</p>	
<p>87. NAME OF OFFICER IN CHARGE</p>		<p>88. NAME OF OFFICER IN CHARGE</p>	
<p>89. NAME OF OFFICER IN CHARGE</p>		<p>90. NAME OF OFFICER IN CHARGE</p>	
<p>91. NAME OF OFFICER IN CHARGE</p>		<p>92. NAME OF OFFICER IN CHARGE</p>	
<p>93. NAME OF OFFICER IN CHARGE</p>		<p>94. NAME OF OFFICER IN CHARGE</p>	
<p>95. NAME OF OFFICER IN CHARGE</p>		<p>96. NAME OF OFFICER IN CHARGE</p>	
<p>97. NAME OF OFFICER IN CHARGE</p>		<p>98. NAME OF OFFICER IN CHARGE</p>	
<p>99. NAME OF OFFICER IN CHARGE</p>		<p>100. NAME OF OFFICER IN CHARGE</p>	



53 7497

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7497  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LULA BOOTH

2. DATE  
OF  
DEATH

Aug. 22, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, in institution: residence before admission)  
A. STATE B. COUNTY

BALTIMORE MD

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTIONPresbyterian Hospital  
Throat & Chancery Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 9-08

D. STREET ADDRESS (If rural, give location)

631 St. Ann's Ave.

Length of stay in Baltimore

10 yrs

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Sept. 14, 1882

9. AGE (In years last birthday)

70

10. Under 1 Year  
Months Days11. Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Domestic

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.

13. FATHER'S NAME

Charles Pruitt

14. MOTHER'S M maiden name

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

HARRY WARD R.D. Salisbury Md.

ADDRESS

18. 420.1 and 260X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion

5 minutes

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Arteriosclerosis

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes mellitus

19A. DATE OF OPERATION

Aug. 18, 1953

19B. MAJOR FINDINGS OF OPERATION

mature cataract, left eye

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 18, 1953, to Aug. 22, 1953, that I last saw the deceased alive on Aug. 21, 1953, and that death occurred at 12:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

John C. Gajewski

M.D.

23B. ADDRESS

1540 Oakridge Road

23C. DATE SIGNED

Aug. 22, 1953

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 26, 1953

24C. NAME OF CEMETERY OR CREMATORY

FARSONS Cemetery

24D. LOCATION (City, town, or county)

Salisbury, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington

25. FUNERAL DIRECTOR

Holloway &amp; Co.

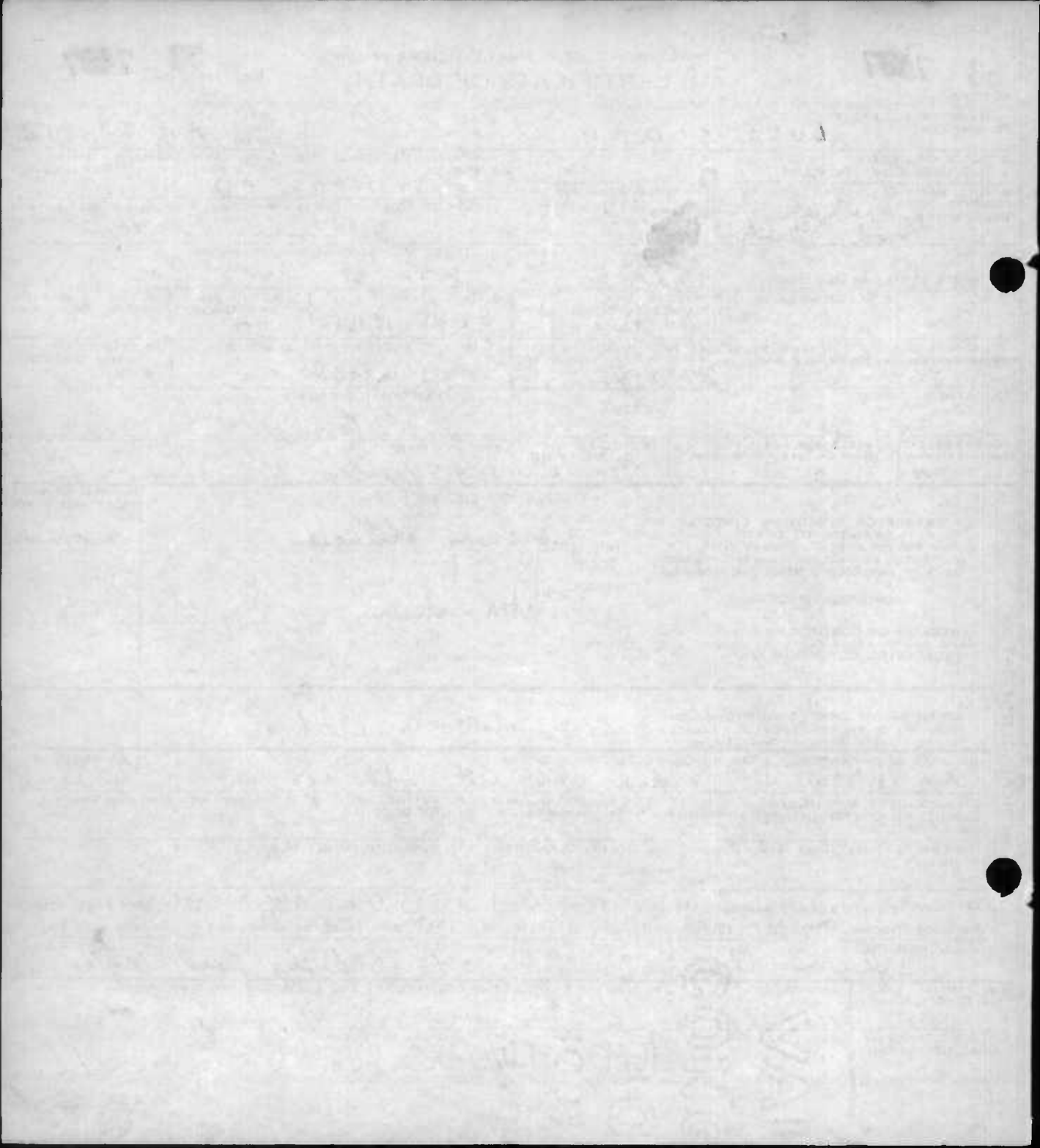
ADDRESS

Salisbury, Md.

VS 150

720 FA

MEDICAL CERTIFICATION



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 7498

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 7498  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM ERNEST BUSSELLS</b>			2. DATE OF DEATH <b>August 22, 1953</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Virginia</b> B. COUNTY <b>V-43</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>USPHS Hospital</b> <b>Wyman Pk. Drive and 31 st. Street</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Kilmarnock</b>		
D. STREET ADDRESS (If rural, give location)					
c. Length of stay in Baltimore <b>1 1/2 yrs.</b>					
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>7/29/89</b>	9. AGE (In years last birthday) <b>64</b>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Night Engineer</b>			11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		
10B. KIND OF BUSINESS OR INDUSTRY <b>Seafarer</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Isaac Milton Rubbells</b>			14. MOTHER'S MAIDEN NAME <b>Susie A. Peed</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Records-USPHS Hospital, Balto., Md.</b>			ADDRESS		
18. <b>420.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>			INTERVAL BETWEEN ONSET AND DEATH		
(A) <b>Congestive Heart failure</b> DUE TO			<b>unknown</b>		
(B) <b>Arteriosclerotic Heart Disease</b> DUE TO			<b>unknown</b>		
(C) <b>Pulmonary Emphysema</b> DUE TO			<b>longstandi</b>		
19. DATE OF OPERATION <b>7</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)			21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			21D. HOW DID INJURY OCCUR?		
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <b>Aug 12</b> , 1953, to <b>Aug. 22</b> , 1953 that I last saw the deceased alive on <b>Aug. 22</b> , 1953, and that death occurred at <b>8:50A</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>John L. Green</b> M. D.			23B. ADDRESS <b>USPHS Hospital, Balto., Md.</b>		
23C. DATE SIGNED <b>8/22/53</b>					
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>8-25-53</b>		
24C. NAME OF CEMETERY OR CREMATORY <b>Kilmarnock, Va.</b>			24D. LOCATION (City, town, or county) (State)		
25. FUNERAL DIRECTOR <b>John O. Mitchell &amp; Sons, Inc.</b>			ADDRESS <b>900 E. Bay Place</b>		

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G-524  
53 7489BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 7489

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

GUNKEL, REV. RUDOLPH J.

2. DATE  
OF  
DEATH

8-22-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

C. H. H.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

MARYLAND

B. COUNTY

C. CITY OR TOWN

BALTIMORE

(If outside corporate limits, write RURAL and give township)

27-15

D. STREET ADDRESS (If rural, give location)

6109 MAYWOOD AVE

Length of stay in Baltimore

41

Mos.  
Days

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

NOV. 30, 1891

9. AGE (in years  
last birthday)

61

If Under 1 Year  
Months: Days

9

If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

MINISTER

10B. KIND OF BUSINESS OR  
INDUSTRY

MINISTER

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN GUNKEL

14. MOTHER'S MAIDEN NAME

HELEN KOERNER.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

C. Hubert Kunkel Jr

ADDRESS

C. H. H.

18. 199.9

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH7 Mo. - 1 wk  
Jan 15-53DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) CARCINOMA.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) UNKNOWN

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Atherosclerotic Heart disease

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-21, 1953, to 8-22, 1953 that I last saw the  
deceased alive on 8-22, 1953, and that death occurred at 11:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Chas E Callens M.D.

M. D.

23B. ADDRESS

Church Home + Hosp

23C. DATE SIGNED

8-22-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

0098W

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs or sections, but the specific words and sentences are difficult to discern.]*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AD 53 7500		BIRTH NO.		CERTIFICATE CORRECTED 8-31-53		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 53 7500	
1. NAME OF DECEASED (Type or Print)						2. DATE OF DEATH					
John E. Trail						Aug. 22-1953					
3. PLACE OF DEATH:						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
A. Baltimore City, Maryland						A. STATE Maryland B. COUNTY Baltimore					
B. FULL NAME OF (If not in hospital or institution, give street address or location)						C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)					
Baltimore City Hospital 4940 Eastern Ave.						BALTO Co GRANET Md					
c. Length of stay in Baltimore						D. STREET ADDRESS (If rural, give location)					
1hr. 25min						Old Court Rd. zone 7 5300					
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Year Months: Days	
M		W		Married		MAR 15 1906		27			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
FARMER				FARMING				BALTO County		YES	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
JOHN A TRAIL						EMMA DELL					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				No		Baltimore City Hospitals Records: 4940 Eastern Ave.					
18. 080.1						CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)						(A) Tracheal Obstruction					
ANTECEDENT CAUSES						(B) Polio Myelitis					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.						(C)					
II						OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				19C. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II			
8-22-1953				Tracheotomy							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)				21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK				21F. HOW DID INJURY OCCUR?			
				m.							
22. I hereby certify that I attended the deceased from 8-22-1953 to 8-22-1953 that I last saw the deceased alive on 8-22-1953 and that death occurred at 5:45A m., from the causes and on the date stated above.											
23A. SIGNATURE						23B. ADDRESS				23C. DATE SIGNED	
472 E. San.						M. D. 4940 Eastern Ave., Baltimore Md.				8-22-1953	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county)		(State)			
BURIAL		8/24/53		PREBYTERIAN CEM		GRANET MD.					
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR		ADDRESS					
AUG 23 1953		Huntington Williams		6411		GEO. P. TOWELL, WINDSOR MILL RD.					
VS 150											

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